# Insurance Orientation Handbook


# 2005

**South Carolina Budget and Control Board**
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211
**803-734-0678** (Greater Columbia area)
**888-260-9430** (toll-free outside Columbia area)
**Web:** www.eip.sc.gov
**E-mail:** cs@eip.sc.gov

# Important Numbers, Addresses and Web Sites

## Aetna – Long Term Care

- Customer Service Phone: 800-537-8521
- Fax: 860-952-2024
- Web: www.aetna.com/group/southcarolina

## APS Healthcare Inc. – SHP Mental Health and Substance Abuse

- Customer Service Phone: 800-221-8699
- Fax: 888-897-8931
- Web: www.apshealthcare.com (password: statesc)

## ASI – TRICARE Supplement Plan

- Customer Service Phone: 800-638-2610, ext. 255
- Fax: 301-816-1125
- Web: www.scemployee29.absmil.net
  www.tricare.osd.mil

## BlueCross BlueShield of South Carolina

**Health—**

- Customer Service Phone:
  803-736-1576 (Greater Columbia area)
  800-868-2520 (toll-free outside Columbia area)
- Fax: 803-699-7675

**Medi-Call—**

803-699-3337 (Greater Columbia area)
800-925-9724 (toll-free outside Columbia area)

- Fax: 803-264-0183
- BlueCard Program Phone: 800-810-BLUE (2583)

**Dental—**

- Customer Service Phone: 888-214-6230
- Fax – Dental: 803-419-3283
- Web: www.southcarolinablues.com

## CIGNA Healthcare HMO

- Member Services Phone: 800-244-6224
- Web: www.cigna.com

## Companion HealthCare HMO

- Member Services Phone:
  803-786-8476 (Greater Columbia area)
  800-868-2528 (toll-free outside Columbia area)
- Web: www.CompanionHealthCare.com

## Employee Insurance Program

- Subscriber Services Phone:
  803-734-0678 (Greater Columbia area)
  888-260-9430 (toll-free outside Columbia area)
- Accounting and Billing Phone: 803-734-1696
- Fax: 803-737-0825
- Subscriber Services E-mail: cs@eip.sc.gov
- Web: www.eip.sc.gov

## Fringe Benefits Management Company – MoneyPlu$

- Customer Service Phone: 800-342-8017
- Fax – Claims: 850-425-4608
- Fax – Other: 850-425-6220
- Web: www.fbmc-benefits.com

## The Hartford – Life Insurance

- Evidence of Insurability Phone: 800-331-7234
- Death Claims Phone: 888-563-1124
- Retiree/Enrollment/Claims Phone: 888-803-7346, ext. 3648
- Conversion Phone: 800-548-5157

## Medco – Prescription Drug Program for SHP and MUSC Options

- Customer Service Phone: 800-711-3450
- Web: www.medco.com

## MUSC Options

- Member Services Phone: 800-821-3023
- Web: www.CompanionHealthCare.com

## Standard Insurance Company – Long Term Disability

- Customer Service Phone: 800-628-9696
- Fax: 800-437-0961
- Medical Evidence Phone: 800-843-7979
- Web: www.standard.com

# Contents

# Introduction

The Employee Insurance Program (EIP) knows your insurance benefits are important to you and to your family. Helping you understand those benefits is important to us. This handbook is for new employees of employers that participate in the state insurance program or employees of employers that have just joined the state insurance program. It will guide you through the enrollment process and will give you information that will help you make the insurance choices that best suit your needs.

**Please review this book and discuss your benefits choices with family members before attending your orientation meeting.** These insurance benefits programs will be explained in detail during orientation. You will make your benefits choices at this meeting.

Certain benefit options are based on your annual salary, so you may need to contact your personnel office to obtain this information. Bring this handbook and any information and documentation you may need, including your annual salary, to your orientation meeting.

The 2005 monthly premiums for the different insurance plans are listed, beginning on page 30. If you are paid twice each month, half of your monthly premiums will be deducted from each check. If you are interested in health maintenance organization (HMO) coverage, you may contact the HMO for benefits information. Telephone numbers for each of the HMOs are on the inside cover.

**Please remember: This booklet is just a brief summary of the insurance benefits that are now available to you.** More detailed information about your coverage and how to use it may be found in materials offered by the HMOs, the *Tax-favored Accounts Guide* from FBMC, and the *Insurance Benefits Guide*. You also may wish to contact your benefits office or to visit the Employee Insurance Program Web site at www.eip.sc.gov.

**The summary of benefits in this handbook does not represent an employee/employer contract. Program provisions are subject to change without notice. This information is designed to assist you in making decisions at enrollment. Please consult your *Insurance Benefits Guide* and information and literature from the HMOs offered in your service area. The *Plan of Benefits Document* and the state basic dental fee schedule are available from your benefits office for specific contractual questions.**

# Eligibility Rules

These are the rules used to determine whether employees and their dependents are eligible for insurance coverage. There are specific eligibility rules for retirees. *See page 3 for more information on retiree eligibility.*

## Employees

An eligible employee is a person who:

- Is employed by the state, a school district or a participating local subdivision
- Works at least 30 hours* a week in a permanent, full-time position, and
- Receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipality councils who also participate in the South Carolina Retirement Systems (SCRS) also are considered employees for insurance purposes. If you work for more than one participating employer (dual employment), please contact your benefits administrator for further information. **Permanent, part-time teachers** are eligible for state health, dental, Dental Plus, MoneyPlu$ and Vision Care Program benefits.

**Employers who participate in the Employee Insurance Program may reduce the threshold for insurance eligibility for permanent employees from 30 hours per week to at least 20 hours per week. Contact your benefits administrator for further information.*

## Dependents

### Spouse

You may cover either your lawful spouse or former spouse (if you are required to do so by a divorce decree or court order), but not both your spouse and former spouse. If you are required to provide health insurance only for your former spouse, you may cover your current spouse under other policies, including dental, long term care and dependent life.

- If you are under a court order to carry your ex-spouse after a divorce, bring a copy of the divorce decree to your orientation meeting.
- If you are in a common-law marriage, bring proof or a notarized statement that you are in a common-law marriage.
- If your spouse is a covered employee or retiree with a participating employer and is carrying you on his insurance, you must be removed from his coverage and enrolled with your own employer.
- You must provide your spouse's date of birth and Social Security number.

### Children

You may cover any of your unmarried children, under age 19, who are principally dependent (more than 50 percent) upon the employee for maintenance and support. This includes a natural or adopted child, stepchild, foster child (a child placed with the employee by an authorized placement agency and for whom the employee cares as he would his own child) or a child for whom you have legal custody and who resides in the home in a normal parent/child relationship, or for whom the

employee provides support and maintenance because of a court order.

- If you are required to cover a dependent child after a divorce, please bring a copy of the divorce decree to your orientation meeting.
- If you provide foster care or are in the process of adopting, please bring documentation of custody if you wish to provide coverage.
- If both you and your spouse are employees or retirees of a participating employer, only one of you may cover your eligible dependents.
- Bring a completed Dependent with Same or Different Last Name form (available from your benefits office or the Employee Insurance Program (EIP) Web site at www.eip.sc.gov) for any dependent child who lives with you in a parent/child relationship but has a different last name.
- You must provide dates of birth and Social Security numbers for your dependent children.

You may cover an unmarried child, age 19 through 24, who is a **full-time student** as defined by the institution and is principally dependent (more than 50 percent) upon you for maintenance and support.

- You must bring the appropriate documentation (a letter from the school's registrar) to your orientation meeting.
- You must also provide dates of birth and Social Security numbers for your dependent children.

You may cover an unmarried child, who is **incapable of self-sustaining employment** because of mental illness or physical handicap, and who is primarily dependent (more than 50 percent) upon you for maintenance and support. The child must have been incapacitated while an eligible dependent. Coverage for your incapacitated dependent child is contingent upon approval from EIP.

- Please bring a completed Incapacitated Child Certification Form (available from your benefits office or the EIP Web site at www.eip.sc.gov) to your orientation meeting.
- You must provide the date of birth and Social Security number for your dependent child.

## Retirees

These rules determine if retirees from participating employers are eligible for insurance coverage after retirement. They apply to retirees who meet one or more of the rules below and who retire:

- Due to years of service with a participating employer or
- Due to age or
- On approved disability through the South Carolina Retirement Systems (SCRS) or
- On approved Basic Long Term Disability and/or Supplemental Long Term Disability

**There are eligibility rules for funded and for non-funded insurance benefits.** "Funded" means your employer contributes the employer's share of your health and dental premiums. "Non-funded" means you pay the full cost of your insurance.

**Please note**: Whether you are a funded or a non-funded retiree, non-qualified service, federal, military and out-of-state employment and service with employers that do not participate in the state insurance program do not count toward your 10- or 20-year eligibility requirement.

Each local subdivision sets its own guidelines for funding retirees. If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.

## Funded retirees:

To be eligible for the state contribution to his insurance premiums, a retiree must fall into one of these categories:

- Employees who are eligible to retire and have 10 or more years[1] of earned South Carolina Retirement Systems service credit with a participating employer. Non-qualified, federal, military, out-of-state and service with employers that do not participate in the state insurance program do not count toward your 10 years eligibility requirement. Your employer **must** participate in the state insurance program.

- Employees who leave employment before they are eligible to retire but have 20 or more years[1] of earned SCRS service credit with a participating employer with the state insurance program. However, they are not eligible for insurance coverage until they are eligible to receive a retirement check at age 60.

- Employees who left employment before 1990 and who were not of retirement age, but who had 18 years of earned SCRS service credit with an employer that participates in the state insurance program, returned to work with a state-covered group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

## Non-funded retirees:

Retirees who do not qualify for funded benefits (see previous rules) must pay the full premium, which includes the retiree share plus the state contribution. Non-funded retirees include:

- Employees who retire at age 55 with at least 25 years[1] of retirement service credit (including at least 10 years of earned service credit with a participating state insurance program employer). You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. Although sick leave may increase service credit under SCRS, retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. At the end of this non-funded period you will be eligible for funded retiree rates. This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judicial Retirement System participants. If you are in one of these groups, contact your benefits office for additional information.

- Employees who are eligible to retire and who have at least five, but fewer than 10, years[1] of earned SCRS service credit with a participating state insurance program employer.

- General Assembly members who leave employment before they are eligible to retire, but who have eight years of General Assembly Retirement System service credit.

- Former municipal and county council members, who served on council for at least 12 years and were covered when they left the council. It is up to the county or municipal council to decide whether to allow former members to have this coverage.

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*[1]Your last five years of employment must have been consecutive and in a full-time, permanent position with an employer that participates in the state insurance program. The additional service credit for unused sick leave may not be used to qualify for retirement.*

- "Buy-in" retirees with at least 10 years[1] of earned retirement service credit with a participating employer and who, before Jan. 1, 2001, established "buy-in" service credit. (You must pay the full insurance premium for the "buy-in" period or to age 60, whichever occurs first. At the end of this period, you will be eligible for funded retiree rates. If you refuse insurance coverage during your "buy-in" period, you must enroll within 31 days of the end of the "buy-in" period or late entry rules will apply. If you enroll before the end of the "buy-in" period, you will then pay the full premium for the remainder of the "buy-in" period or until you reach age 60.

To continue your insurance coverage into retirement, you **must** enroll as a retiree by completing a Retiree Notice of Election (NOE) form within 31 days of the date of your retirement or within 31 days of your disability approval. If you and/or your dependents are not covered at the time of your retirement, you may enroll within 31 days of your retirement date or within 31 days of a special eligibility situation (page 25). You will be subject to pre-existing condition limitations for 12 months. A Certificate of Creditable Coverage may be used to reduce the limitation period. See page 7 for more information. If you and/or your dependents do not enroll within 31 days of a special eligibility situation, you may enroll during an open enrollment period held in October every odd-numbered year (2005) as late entrants (page 6). Your coverage would take effect January 1.

If you are a Teacher and Employee Retention Incentive Program (TERI) participant, you are retired for retirement benefit purposes only. Your insurance benefits are the same as an active employee's, if you are eligible. Your service as a TERI participant in a full-time, permanent position with a participating insurance program employer may be applied toward retiree insurance eligibility.

## Survivors

If you are a covered spouse or child of a deceased employee, or funded retiree, of a state agency or a school district, your health insurance premium will be waived for one year after the death of the employee or retiree. Local subdivisions may elect to, but are not required to, waive the health premiums of survivors of retirees. After the first year, you must pay the full premium to continue coverage. Dental premiums are never waived.

- If the deceased was a covered employee who was killed in the line of duty on or after Jan. 1, 2002, health insurance premiums will be waived for one year for the covered surviving spouse and dependent children. After the one-year waiver, eligible survivors may continue coverage at the employer-funded rate. If the employer is a local subdivision, survivors should contact the employer for premium information.

- A surviving spouse who remarries becomes ineligible to continue coverage.

- A dependent child can continue coverage until age 19 or until age 25 if he is a full-time student. (Documentation is required.) A dependent child, who marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support, becomes ineligible to continue coverage.

- An incapacitated child may continue coverage beyond the age requirements. (Medical documentation is required.) He becomes ineligible for insurance coverage if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support.

# Enrollment

To enroll in an insurance program, you must complete a Notice of Election (NOE) form. To cover your eligible dependents, each dependent must be listed on the NOE form. **Do not forget to include their Social Security numbers!** If you have a dependent, age 19-24, who is a full-time student, you must bring verification of his student status on letterhead from the registrar of the institution he attends. The completed NOE must be submitted to your personnel office within 31 days of your date of hire.

You must complete separate applications to enroll in MoneyPlu$ accounts and Long Term Care.

A sample NOE is included on pages 27-28. It may be helpful to you to practice completing the form before your orientation meeting. This will assist you in gathering the information you need for your orientation meeting.

After you enroll, you should check your payroll stub to make sure your payroll deductions agree with the benefit level you selected. Your coverage will continue from one year to the next, with the exception of MoneyPlu$ accounts (see page 20), as long as you are an eligible employee.

# When Coverage Begins

Your coverage begins on the first day of the month coinciding with, or after, the date you begin employment and are actively at work. Coverage for your enrolled dependents begins when your coverage becomes effective.

## Coordination of Benefits

Coordination of benefits is a system to ensure that if you are covered by more than one insurance plan, both plans pay their share. Benefits under the two plans are limited to no more than 100 percent of the claim. The plan that pays first is the *primary* plan. The plan that covers you as an employee is primary to the plan that covers you as a dependent. When you and your spouse cover your dependent children on two different plans, the parent with the earlier birthday must file claims first with his insurance. Be aware that if both you and your spouse are covered employees or retirees with a participating employer, only one of you may cover your eligible dependent children, and you cannot cover each other as a dependent spouse.

## Coordination of Benefits with Medicare

If you are eligible for Medicare and are enrolled as an active employee, your state health plan coverage is primary. (Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.) Upon enrollment at retirement, Medicare Parts A and B become your primary coverage. It is important to enroll in Medicare Part B if you are covered as a retiree, since the State Health Plan will coordinate with Part B benefits when you are eligible for Medicare (generally, at age 65), even if you are not enrolled in it.

## Late Entrant

A late entrant is full-time employee, retiree or dependent who is not enrolled within 31 days of his first date of eligibility and who later enrolls during open enrollment. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

# Pre-existing Condition

A pre-existing condition limitation period applies to the health plans (both the State Health Plan and the health maintenance organizations) and the Basic and Supplemental Long Term Disability plans.

## Health Plans

A pre-existing condition is any medical condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed healthcare provider or practitioner in the six months before the covered person's enrollment date under the plan. Benefits for a pre-existing condition are payable only for treatment rendered 12 months (18 months for a late entrant) after the enrollment date of a covered person. If you have been insured previously, you may reduce the pre-existing condition period by providing certification of prior health insurance coverage if the break in coverage did not exceed 62 days.

## Long Term Disability Plans

A pre-existing condition is an injury, disease, mental disorder or pregnancy for which you consulted a doctor, received medical treatment or took prescribed drugs during the six-month period before the date your insurance coverage became effective.

## Certificate of Creditable Coverage

Creditable coverage is prior coverage under a group health plan or insurance coverage or health benefits provided as described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage may be used to reduce a pre-existing condition limitation period, if the prior coverage was continuous (any break in coverage did not exceed 62 days). If you and/or your dependents are enrolling in a state health plan for the first time, you are responsible for obtaining and submitting a certificate of creditable coverage with your enrollment form.

# COBRA

COBRA is short for the *Consolidated Omnibus Budget Reconciliation Act*. It requires that continuation of group insurance coverage be offered to you and to your covered dependents if you are no longer eligible for coverage under this Plan.

You can continue your coverage for a limited time under COBRA if you and/or your covered dependents lose coverage because:

- Your working hours are reduced from full-time to part-time
- You voluntarily quit work, are laid off or are fired (unless the firing is due to gross misconduct)
- You are a separated or divorced spouse or
- You are no longer eligible as a dependent child

Rules and regulations governing continuation of coverage under COBRA are described in your *Insurance Benefits Guide*. If you need additional information, you may contact EIP. If you are enrolled through a local subdivision, contact your benefits office.

# Choosing a Health Plan

## Enrollment Periods

There are two types of enrollment periods: **annual enrollment** and **open enrollment**. Annual enrollment, held every year in October, is a period during which eligible employees and retirees may change health plans. No other changes are allowed. Retirees may not change to or from the Medicare Supplemental Plan. Open enrollment, held in October of odd-numbered years, is a period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan and/or dental plan without regard to any special eligibility situations. Retirees may change to and from the Medicare Supplemental Plan.

Enrollment changes become effective January 1.

## What are my Choices?

**The State Health Plan (SHP)**

The SHP is a Preferred Provider Organization (PPO) that has arrangements with doctors, hospitals and other providers who have agreed to accept the Plan's allowable charges for covered medical services as payment in full and will not *balance bill* you. (Balance billing is when a provider charges more for medical services than the Plan allows.) Participating providers also file the claims for you. With the SHP, you are free to use any provider you choose, except for behavioral health providers and pharmacies. The SHP has three options: the *Standard Plan*, the *Savings Plan* and the *Medicare Supplemental Plan*. The Standard and Savings plans are offered statewide to active employees, COBRA subscribers, survivors and retirees. (Retired subscribers who are eligible for Medicare may not enroll in the Savings Plan.) The Medicare Supplemental Plan is offered statewide to retirees and survivors who are enrolled in Medicare.

**Traditional Health Maintenance Organizations (HMOs)**

An HMO is a managed care plan that requires subscribers to see only providers within its network. If you receive care outside the network, the HMO will not pay benefits for these services, unless the care is pre-authorized or you have a life- or limb-threatening illness or injury. You are required to choose a primary care physician (PCP) who coordinates all aspects of your healthcare. To receive benefits, you must receive a referral from your PCP before you see a specialist. Active employees must live or work in an HMO service area to enroll in its plan. Retirees, COBRA subscribers and survivors must live in an HMO service area to enroll in its plan. Choices are:

- **Companion HMO—**offered **statewide.**
- **CIGNA HMO**—offered in all counties **except Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda**.

**HMO with Point of Service (POS) Option**

A POS plan is an HMO that allows you to go to providers inside or outside its network. To receive the highest level of benefits, care must be obtained within the HMO network and be authorized by the HMO. When you use out-of-network services, you are likely to have much higher out-of-pocket expenses in the form of deductibles and copayments. The only HMO with a POS option offered is MUSC Options, which is available in **Berkeley, Charleston, Colleton and Dorchester** counties. Active employees must live or work this

service area to enroll in the plan. Retirees, COBRA subscribers and survivors must live in the service area to enroll in the plan. MUSC Options is not available to retirees who are enrolled in Medicare.

**TRICARE Supplement**

The TRICARE Supplement is available only to TRICARE-eligible employees and to retirees who are eligible for TRICARE but who are not eligible for Medicare. TRICARE is the Department of Defense's health insurance program for the military community. The TRICARE Supplement plan is secondary coverage to TRICARE. It pays the cost share, deductible and excess charges under the TRICARE Standard and Extra options so that on a combined basis, eligible participants have 100 percent coverage in most cases.

The TRICARE Supplement is available to:

- Family members and survivors of active-duty military personnel
- Military retirees, their spouses or surviving spouses under age 65 and their unmarried, dependent children under age 21 or under age 23 if a full-time student
- Retired reservists, Guardsmen and their families, if the reservists are between ages 60 and 65 and have at least 20 creditable years of military service
- Spouses and unmarried dependent children of reservists who are ordered up to active duty for more than 30 days (they are covered only during the reservist's active duty tour), or reservists who died while on active duty
- Former spouses of active-duty or retired military who were married to a service member or former service member who had at least 20 years of creditable service for retirement purposes when a divorce or annulment occurred
- Spouses and unmarried eligible dependent children who are eligible for CHAMPVA and
- Retired covered employees who are under the age of 65 and eligible for TRICARE

To participate in the TRICARE Supplement plan, you **must** be registered with the Defense Enrollment Eligibility Reporting System (DEERS) and must be under age 65 unless ineligible for Medicare. You must drop your SHP or HMO coverage to enroll in the plan. For more information, visit www.scemployee29absmil.net or call 800-638-2610, ext. 255.

# Making a Decision

Choosing a health plan requires thought and planning. Costs, services provided, benefits offered and provider networks are all major factors to consider when making a health plan decision. Although no plan will cover all of your medical costs, there are plans that are better suited than others for you and your family's health needs.

You cannot predict exactly what your healthcare needs will be for the coming year, but you can anticipate to some extent what services you and your family might need. By taking the time to decide what benefits and services are important to you and your family and comparing the available plans, you will be able to choose a health plan that is right for you.

# What Benefits are Offered?

Although most plans provide basic health coverage, the details are what count. When choosing a plan, you may want to find out how it covers:

- Specialist care
- Emergency room visits and hospitalizations
- Prescription drugs

- Mental health and substance abuse services
- Obstetrical-gynecological care and well child care visits
- Physical exams
- Health screenings and other preventive care
- Nursing home, home health and hospice care
- Physical therapy and other rehabilitative care
- Vision care
- Chiropractic or alternative health care
- Medical services outside the service area

## What is Important to me?

Before choosing a health plan, decide what is most important to you. You may want to consider:

- How you feel about a primary care doctor making referrals for you
- How much responsibility, financially and otherwise, you are willing to take for your own healthcare
- Whether freedom to choose which doctor or hospital to use is important to you
- How comprehensive you want your healthcare coverage to be
- How important the cost is to you and how much you can pay in premiums, deductibles and other expenses
- Whether the plan offers benefits that meet your needs. Are you thinking about starting a family? Do you or does a member of your family have a chronic condition or disability?
- How does the plan provide coverage for family members who travel or attend college out of the state or the service area?

## How do I Compare Plans?

When comparing the health plans, look at the services each plan offers. What services are limited or not covered (exclusions)? Which doctors, hospitals and other providers participate in the plan's networks (i.e., does your doctor participate)? Are the doctors accepting new patients? Do you need approval from the plan or your primary care physician before going to the hospital or receiving specialty care? Finally, compare the costs. Consider things such as: deductibles; copayments; how much the plan will pay once your deductible has been met; how much the plan will pay if you use a non-participating provider; and the limits on how much the plan will pay in a year or over a lifetime.

# The State Health Plan

The State Health Plan offers two choices: the **Standard Plan** and the **Savings Plan**.

The **Savings Plan** is new in 2005. If you are willing to take greater responsibility for your health and accept a higher annual deductible, you can save money on premiums. Because it is a tax-qualified, high-deductible health plan, an eligible subscriber who enrolls in the Savings Plan and who has *no other health coverage, including Medicare, that is not a high-deductible health plan,* may establish a Health Savings Account (HSA). An HSA may be used to pay qualified medical expenses now and in the future.

Each plan has its own cost-sharing provisions. With the **Standard Plan,** the annual deductibles are lower, but the premiums are higher. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. Afterwards, the Standard Plan pays 100 percent of the allowable charges. However, per-occurrence and per-visit deductibles still apply.

With the **Savings Plan**, the annual deductibles are much higher, but the premiums are much lower. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. The Savings Plan then pays 100 percent of allowable charges. However, with the Savings Plan, charges for out-of-network services do not apply to this maximum. There are no per-occurrence deductibles with the Savings Plan.

As part of the State Health Plan, the Standard Plan and the Savings Plan share many features:

## The State Health Plan Hospital Network

All general hospitals in South Carolina participate in the SHP hospital network. Network hospitals accept State Health Plan's allowable charges for covered services and will not balance bill you for the difference. Network hospitals also file your claims. You pay only the deductible, the coinsurance that applies to you and any non-covered charges.

Services at non-network hospitals are covered, but non-network hospitals can balance bill you for the difference between the State Health Plan's allowable charge and their charge. You will also be responsible for paying an additional 20 percent in coinsurance, the out-of-network differential (see page 13).

## The State Health Plan Physician Network

If you need to see a medical doctor, you may benefit from using the SHP Physician Network. The SHP Physician Network is an open network, which means all eligible doctors in the state were invited to participate. Since network physicians have agreed to accept the Plan's allowable charges for covered medical services, you will pay only your deductibles, your coinsurance and any non-covered charges.

## The BlueCard Program

You have access to doctors and hospitals almost everywhere with the BlueCard Program administered by BlueCross BlueShield of South Carolina. This program applies to your medical benefits. Please refer to the Behavioral Health Benefits section on page 16 to see how mental health and substance abuse benefits are handled. With the BlueCard you still have the freedom to choose the

doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home within the United States:

1. Always carry your SHP ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard *Access* at 800-810-2583.
4. Call Medi-Call for pre-certification or prior authorization, if necessary.
5. When you arrive at the participating doctor's office or hospital, simply show your SHP ID card. As a BlueCard program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.

After you receive care, you should not have to complete any claim forms. You should not have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayment, coinsurance and non-covered services). You will be mailed a complete explanation of benefits.

Outside the United States, follow the same process as in the United States, with these exceptions:

- In most cases, you should not need to pay up front for inpatient care at BlueCard Worldwide hospitals. You are responsible for the usual out-of-pocket expenses (deductibles, copayment, coinsurance and non-covered services). The hospital should submit your claim.

- You pay the doctor or hospital for inpatient care at non-BlueCard Worldwide hospitals, outpatient hospital care and other medical services. You will then complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator or online at www.southcarolinablues.com.

- Outside the United States you can call 800-810-2583 or call collect at 804-673-1177, 24-hours-a-day, seven days a week, for information on doctors, hospitals and other healthcare professionals or to receive medical assistance around the world. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization, if necessary.

The Medicare Supplemental Plan follows Medicare rules. Since Medicare does not provide worldwide coverage, BlueCard Worldwide coverage is **not** available to Medicare Supplemental Plan subscribers.

## Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes 24 ambulatory surgical centers around the state that provide some of the same services obtained from the outpatient department of a hospital. These surgical centers accept State Health Plan allowable charges and will not balance bill you for the difference. You just pay the applicable deductible and coinsurance. Medically necessary services at non-network ambulatory surgical centers are covered, but you may pay more.

## Out-of-Network Benefits

With the State Health Plan, you may choose which provider to use. However, if you choose a provider that does not participate in a SHP network or the BlueCard program, you will pay 20 percent more in coinsurance. This means that after you meet your deductible, you will be respon-

sible for 40 percent of your covered expenses. Non-network providers are free to charge you any price for their services, so you may pay more than the State Health Plan's allowable charge.

Once you have met your deductible, here's how the **out-of-network differential** works if you are covered under the Standard Plan:

- If you have met your deductible and choose to see a non-network provider, you will be responsible for 40 percent, instead of the usual 20 percent, of the covered charges, any applicable per-occurrence or per-visit deductibles, and risk being balance billed. The plan will not begin paying 100 percent of your allowable charges until you have reached the out-of-network coinsurance maximum of $4,000 for single coverage and $8,000 for family coverage.

Once you have met your deductible, here's how the **out-of-network differential** works if you are covered under the Savings Plan:

- If you have met your deductible and choose to use a non-network provider, you will be responsible for 40 percent, rather than the usual 20 percent, of the covered charges. Since there is no out-of-network coinsurance maximum under the Savings Plan, the Plan will never pay all of your allowable charges.

Prescription drug and mental health and substance abuse benefits are **not** payable, unless you use a network provider.

## Medi-Call

Certain services covered by the Standard Plan and the Savings Plan require approval before you receive them. A phone call gets things started. While your healthcare provider **may** make the call for you, it is your responsibility to call for authorization. The Medi-Call numbers are:

- **800-925-9724 (South Carolina, nationwide, Canada)**
- **803-699-3337 (Greater Columbia area)**

You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving these medical services at any medical facility in the United States or Canada:

- You need inpatient care in a hospital[1]
- Your precertified outpatient services result in a hospital admission (you must call again for the hospital admission)
- You need outpatient surgery for septoplasty, hysterectomy or sclerotherapy
- You need a MRA, MRI or CT Scan
- You will be receiving chemotherapy or radiation therapy
- You need a second opinion
- You are admitted to a hospital in an emergency situation (your admission must be reported within 48 hours or the next working day) [1]
- You are pregnant (you must call within the first three months of your pregnancy)
- You have an emergency admission during pregnancy[2]
- You deliver your baby[2]
- Your newborn has complications at birth
- You are admitted to a skilled nursing facility, use home healthcare, hospice care or an alternative treatment program or need durable medical equipment

- You or your covered spouse decides to undergo any In Vitro Fertilization (IVF) procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech and occupational therapies
- A description of any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery (i.e., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery)

[1] *For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for precertification before admission, or within 24 hours of an emergency admission.*

[2] *Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by completing and filing an NOE, within 31 days of birth for benefits to be payable.*

Medi-Call approval does not guarantee payment of benefits. Claim payments are still subject to the rules of the Plan.

If you do not call Medi-Call when required, you must pay a $200 penalty for each hospital or skilled nursing **facility admission.** In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket.

# Transplant Contracting Arrangements

The SHP transplant contracting arrangements include the Blue Cross and Blue Shield Association (BCBSA) national transplant network, Blue Quality Centers for Transplants (BQCT). The BQCT is a national network of transplant centers. All of the centers in the BQCT network meet specific criteria that consider not only provider qualifications and program process, but patient outcomes as well.

# Preventive Benefits

## Worksite Screening

Active employees and retirees who are not Medicare eligible whose primary coverage is the Standard Plan, the Savings Plan, Companion HMO, CIGNA HMO or MUSC Options can pay $15 for a routine health screening. It includes a health risk appraisal, blood lipid profile, blood chemistry profile, hemogram, blood pressure measurement, height and weight measurement and counseling on individual health risk factors. The screening, conducted at your worksite, is administered through Prevention Partners. You may participate in only one screening per year. Prevention Partners also conducts chronic disease management workshops on asthma, diabetes, hypertension and healthy heart. These workshops are held statewide and are free to employees and their family members. Contact your Prevention Partners coordinator or benefits office for more information.

## Mammography Testing Program

Covered female subscribers within certain age ranges can obtain routine four-view mammograms at no cost at 95 participating facilities throughout the state. There are no claim forms to file, and a physician's referral is not required. Routine mammograms are not covered at nonparticipating facilities in South Carolina and the bordering states. Diagnostic mammograms are covered subject to deductibles and coinsurance.

## Pap Test Benefit

The Plan will pay yearly for a Pap test if you are a covered female age 18 through 65. This benefit applies whether the Pap test is routine or diagnostic. However, it does not include the office visit or other lab charges. Deductibles and coinsurance do not apply to this benefit.

## Maternity Management Program

The Maternity Management Program is designed to help mothers-to-be covered by the State Health Plan receive prenatal care. The Medi-Call penalty will apply if you fail to contact Medi-Call during the first trimester to certify your pregnancy.

## Well Child Care Benefits

Well Child Care benefits are free, and there are no claims to file when a doctor in the State Health Plan Physician Network provides the services. Covered dependent children from birth through age 12 are eligible for the Well Child Care benefit. When you use a network doctor, the Well Child Care benefit pays 100 percent of the cost of covered childhood immunizations. The Well Child Care benefit also provides 100 percent coverage for routine checkups at specified ages when obtained from a network doctor.

## Preventive Benefits for Savings Plan Participants

Savings Plan participants are encouraged to take greater responsibility for their health. To make that easier, the plan offers additional preventive benefits at no cost. They include:

- Reimbursement for a yearly flu shot for each eligible participant
- Access to the 24-hour Health at Home® Nurseline, through which registered nurses provide personal, immediate assistance to subscribers
- A copy of the 416-page, full-color self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care*

Children age 12 and younger receive the Well Child Care benefits that are also offered to those enrolled in the Standard Plan. Savings Plan participants age 13 and older may receive from a network provider an annual physical that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel "blood work"
- A lipid panel every five years
- A Pap test

# Prescription Drug Benefits

The Prescription Drug Program, administered by Medco, is easy and convenient to use. Please remember, **prescription drugs are only covered at network pharmacies**.

Under the **Standard Plan**:

- You show your SHP ID card when you purchase your prescriptions from a network pharmacy and pay a copayment of either $10 for generic drugs, $25 for preferred brand or $40 for non-preferred brand medications for up to a 31-day supply. If the price of your prescription is less than the copayment, you pay the lesser amount. Prescription drug benefits

are payable without an annual deductible, and there is an annual $2,500 copayment maximum per person.

Under the **Savings Plan**:

- You pay the full allowable cost of your prescription drugs when you purchase them. There are no copayments. This cost is transmitted electronically to BlueCross BlueShield of South Carolina. If you have not met your annual deductible, the full allowable cost of the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the allowable cost of the drug. The remaining 20 percent of the cost of the drug will be credited to your coinsurance maximum.

Both plans have a "**pay-the-difference**" policy. This means that if you purchase a brand-name drug when an equivalent generic drug is available, the plan will only cover the cost of the generic drug. This policy will apply even if the doctor prescribes the medication as "Dispense As Written" or "Do Not Substitute."

Under the **Standard Plan**, if you purchase a brand-name drug instead of a generic, you will be charged the generic copayment, PLUS the difference in price between the brand name and the generic drug. If this amount is less than the preferred or nonpreferred brand copayment, you will pay the applicable brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan**, if you purchase a brand-name drug instead of a generic, only the allowable cost for the generic drug will apply toward your deductible. After you have met your deductible, only the allowable cost of the generic drug will apply toward your coinsurance maximum.

Prescription drugs are available at a discount by mail. For details, see the *Insurance Benefits Guide*.

## Behavioral Health Benefits

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims. There are no caps on the number of provider visits.

If you need to see a mental health care provider, call APS Healthcare, toll-free at 800-221-8699, and you will be directed to a national network of providers. The mental health and substance abuse provider network operates just like the physician network. The major differences are that no benefits are paid if you use a hospital or provider that does not participate in the network, and services, including hospital admissions, are covered only if they are pre-authorized. The mental health and substance abuse provider network is an open network. This means that any eligible provider can participate in it. Your participating provider is responsible for submitting claims for these services, so there are no claims for you to file.

Remember, if you do not call APS Healthcare for pre-authorization or if you choose to use a non-network provider or hospital, no benefits will be paid. A list of providers who are part of the State Health Plan's mental health and substance abuse provider network is available through the EIP's Web site at www.eip.sc.gov or at the APS Web site at www.apshealthcare.com.

# State Dental Plan

The State Dental Plan is provided to active employees and funded retirees at no cost. You may add your eligible dependents for an additional premium, and they do not have to be enrolled in a health plan. Dental plan benefits are divided into these categories, or *classes:*

| Class | Services Covered | Yearly Deductible | Percent Covered | Maximum Benefit |
|---|---|---|---|---|
| **I Diagnostic and Preventive** | Diagnostic and preventive procedures<br>Cleaning and scaling of teeth<br>Fluoride treatment<br>Space maintainers (child)<br>Emergency pain relief<br>Radiographs (X-rays) | None | 100% of allowable charges | $1,000 per person each benefit year combined for Classes I, II and III |
| **II Basic** | Fillings<br>Simple extractions<br>Oral surgery<br>Surgical extractions<br>Preparation of mouth for dentures | $25 per person<br>If you have services in Classes II and III, you still pay only one deductible<br>Limited to three per family per year | 80% of allowable charges | $1,000 per person each benefit year combined for Classes I, II and III |
| **III Prosthetics** | Onlays<br>Crowns<br>Bridges<br>Dentures<br>Repair of prosthetic appliances | $25 per person<br>If you have services in Classes II and III, you still pay only one deductible<br>Limited to three per family per year | 50% of allowable charges | $1,000 per person each benefit year combined for Classes I, II and III |
| **IV Orthodontia** | Limited to covered children under age 19<br>Correction of malocclusion<br>Consisting of: diagnosis (including models and radiographs)<br>Active treatment (including necessary appliances) | None | 50% of allowable charges | $1,000 per lifetime for each covered child |

# Dental Plus

Dental Plus provides a higher level of coverage for dental services covered under the State Dental Plan. It is not an offset program that pays what the State Dental Plan does not. Instead, it covers the *same procedures and services* (except orthodontia) at the *same percentage rate of coverage* as the State Dental Plan, but at a *higher* allowance (dollar amount) for the charges. Dental Plus provides this higher level of coverage at affordable rates.

You pay Dental Plus premiums with no contribution from the state. Active employee premiums can be paid on a pretax basis through MoneyPlu$. Dental Plus premiums are **in addition** to State Dental Plan premiums. Dental Plus subscribers are required to carry the same level of coverage that they are enrolled in under the State Dental Plan.

Under Dental Plus, reimbursement is based on what your dentist charges, up to the maximum Dental Plus allowance. The allowance is based on what most dentists in South Carolina charge for particular services. This means that your dental expenses will probably fall within these allowances, and you will only be responsible for paying the deductible and coinsurance. If your dentist charges more for covered services than Dental Plus allows, **you** will be responsible for paying the difference unless your dentist has agreed to accept the Dental Plus allowance.

The combined annual maximum benefit for the State Dental Plan and Dental Plus for services in classes I, II and III is $1,500 per covered person (compared to $1,000 with the State Dental Plan alone). There are no additional deductibles and coinsurance under Dental Plus.

# Life Insurance (for active employees only)

## Basic Life Insurance

The employer provides $3,000 group term life and accidental death and dismemberment coverage at no cost if you are enrolled in a health plan offered by EIP. The Hartford Insurance Company administers this benefit. If you leave your job, you may convert your coverage to an individual policy. To do so, you must apply to The Hartford in writing within 31 days of the date your insurance under this plan ends and pay the required premiums for your age and class of risk.

## Optional Life Insurance

You can enroll in the Optional Life Insurance Plan within 31 days of the date you are hired. You do not have to be enrolled in health or dental coverage to participate in the Optional Life program. This policy includes life, accidental death benefits (including day care, education and felonious assault benefits), a prorated benefit for loss of eye or limb, a living benefit for employees under age 60, a 12-month waiver of premium for disability, and a seat belt provision of an additional 25 percent of the accidental death benefit (when applicable).

As a new employee, you can elect coverage in $10,000 increments, up to three times your basic annual earnings rounded down, without providing medical evidence of good health. You can select a higher benefit level in increments of $10,000, up to a maximum of $500,000, by providing medical evidence of good health. Your coverage begins on the first day of the month coinciding with, or the first of the month after, your date of employment if you are actively at work on that day as a full-time employee. If you apply for an amount of coverage that requires medical evidence of good health, your coverage effective date will be the first of the month after approval.

If you participate in the MoneyPlu$ Pretax Group Insurance Premium Feature, you can increase, decrease or drop your coverage only during the October annual enrollment period or within 31 days of a special eligibility situation. To increase your coverage during annual enrollment, you must provide medical evidence of good health and be approved by The Hartford. If approved, coverage will be effective on January 1 after annual enrollment as long as you are actively at work on that day as a full-time employee. You can increase your coverage due to a special eligibility situation in increments of $10,000, up to $50,000, without providing medical evidence of good health. You can increase your coverage further *with* medical evidence. Remember that a salary increase does not constitute a special eligibility situation. If you do not participate in the MoneyPlu$ Pretax Premium Feature, Optional Life enrollment and coverage changes are allowed year-round (subject to approval of medical evidence).

You can pay Optional Life insurance premiums before you pay taxes through MoneyPlu$. Your entire Optional Life insurance premium will be deducted from your paycheck before taxes. However, only premiums for coverage up to $50,000 will be tax exempt. Premiums paid for additional coverage (more than $50,000) will be added back into your earnings on your W-2 form at the end of the year. Please refer to the MoneyPlu$ section for enrollment information. Your premiums will increase automatically each January 1 after you enter a new age bracket. When you retire, you may continue your coverage in $10,000 increments up to your active coverage level until age 75. Benefits are reduced by 35 percent at age 70. Premiums and reduced coverage levels are on pages 33-35. An employee leaving his job or retiring at age 75 can convert to a whole life policy up to the final face value of the coverage.

## Dependent Life Insurance

You do not have to be enrolled in health or dental coverage to enroll in the Dependent Life program. Dependents can be a spouse, who is not eligible as an employee of a participating employer, and a dependent child between the ages of 14 days and 19 years, or up to age 25 if he is a full-time student. A child becomes ineligible for Dependent Life coverage at age 19 if he is not a full-time student, if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support. An incapacitated child becomes ineligible if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support.

## Dependent Life — Spouse

Within 31 days of the date you begin employment or within 31 days of your marriage, you can enroll your spouse for up to $20,000 in life insurance without providing medical evidence of good health. Medical evidence of good health is required for late entry for a spouse. If you are enrolled in Optional Life, you may cover your spouse in increments of $10,000, up to 50 percent of your Optional Life coverage or $100,000, whichever is less.

If you are not enrolled in Optional Life, you may elect coverage for your spouse in the amount of $10,000 or $20,000. Premiums for Dependent Life spouse coverage, just like Optional Life premiums, are based on the **employee's** age. You pay the premium with no contribution from the state, and it is payable through payroll deduction. The employee is the beneficiary.

## Dependent Life — Children

You can cover your eligible dependent children for $10,000. Medical evidence is not required to cover a child, even if the child is a late entrant. The monthly premium for Dependent Life child coverage is $1.32 regardless of the number of children covered. You pay the entire premium with no contribution from the state, and it is payable through payroll deduction.

Your dependent's coverage will end at midnight on the earliest of:

- The date the policy ends
- The date you, the employee, are no longer eligible for Dependent Life insurance coverage
- The date the dependent no longer meets the definition of a dependent or
- The date premiums for Dependent Life insurance coverage are due and unpaid for a period of 31 days

If your dependent's coverage ends because of one of the reasons above, he may convert his coverage to a personal life insurance policy. To do so, the dependent must apply to The Hartford in writing within 31 days of the date his insurance under this plan ends and pay the required premiums for his age and class of risk.

# MoneyPlu$

MoneyPlu$ is a program that includes tax-favored accounts, which are IRS-approved tax-free benefits. They save you money on eligible medical and dependent care costs by enabling you to pay these expenses with income deducted from your salary before it is taxed.

- **Pretax Premiums** (for active employees)
  The Pretax Group Insurance Premium Feature allows you to pay your State Health Plan, HMO, State Dental Plan, Dental Plus and Optional Life (for coverage up to $50,000) premiums before taxes are taken from your paycheck.

- **Flexible Spending Accounts** (for active employees)
  MoneyPlu$ allows you to pay eligible medical and dependent care expenses with money before it is taxed. You authorize deposits to your MoneyPlu$ account every pay period, before your salary is taxed. As you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are three kinds of MoneyPlu$ accounts: a Medical Spending Account, a limited-use Medical Spending Account that can accompany a Health Savings Account and a Dependent Care Spending Account. If you incur dependent care and medical expenses, you can establish both a dependent care account and a Medical Spending Account or a limited-use Medical Spending Account.

- **Health Savings Accounts** (for active employees and non-Medicare eligible retirees)
  A MoneyPlu$ Health Savings Account (HSA) is available to subscribers enrolled in the SHP Savings Plan and can be used to pay healthcare expenses. Unlike money in a MoneyPlu$ Medical Spending Account, the funds do not have to be spent in the year they are deposited. Money in the account accumulates tax free, so the funds can be used to pay qualified medical expenses in the future. An important advantage of the HSA is that you own it. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

**Administrative Fees**

Pretax Group Insurance Premium Feature ..... $0.12 per month
Dependent Care Spending Account ..... $2.50 per month
Medical Spending Account or limited-use MSA ..... $2.50 per month
*All fees are deducted from your paycheck before taxes.*

EZ REIMBURSE® MasterCard® ..... $20 per year
*The fee for this optional debit card will be deducted from your Medical Spending Account.*

**Health Savings Account:**

- $20 per year or $2 per month (your choice)
- 50 cents per check if you are reimbursed by check.
- No charge if you use your VISA® debit card.

*There may be additional fees for other services. All fees are deducted from your HSA.*

# Disability Insurance

**Basic Long Term Disability (BLTD)** is an employer-funded disability plan for active employees who are enrolled in a health plan offered by the Employee Insurance Program. BLTD provides a benefit of 62.5 percent of the employee's gross monthly salary, less other sources of income, up to a maximum benefit of $800 per month. There is no minimum benefit if these offsets exceed 62.5% of the employee's gross monthly salary. BLTD has a 90-day benefit waiting period.

Upon approval, these taxable benefits are payable for up to 24 months if an employee is unable to perform the duties of his own general occupation, and up to age 65 or older, in some circumstances, if an employee is unable to perform the duties of any and all occupations which he is able to perform, due to education, training or experience. These alternative occupations must be available at one or more locations in the national economy. They must be occupations in which the employee can be expected to earn at least 65 percent of his pre-disability earnings (adjusted for inflation) within 12 months following his return to work, regardless of whether the employee is working in his previous occupation or any other occupation. In addition, there is a two-year limit on benefits for certain medical conditions.

BLTD is provided to active employees only and cannot be continued upon retirement.

**Supplemental Long Term Disability (SLTD)** is a voluntary program in which the employee pays all premiums. This benefit pays 65 percent of the employee's gross monthly salary, less other sources of income, including the BLTD benefit, up to a monthly maximum of $8,000. If these other sources of income exceed 65 percent of the employee's gross monthly salary, the plan will pay a minimum of $100 per month.

These non-taxable benefits are payable for 24 months if an employee is unable to perform the duties of his own occupation, and up to age 65 or older, in certain circumstances, if the employee is unable to perform the duties of any and all jobs which he is able to perform, due to education, training or experience. These alternate occupations must be available at one or more locations in the national economy. They must be occupations in which the employee can be expected to earn at least 65 percent of his pre-disability earnings (adjusted for inflation) within 12 months following his return to work, regardless of whether the employee is working in his previous occupation or any other occupation. In addition, there is a two-year limit on benefits for certain medical conditions.

The employee may choose, at enrollment, either a 90-day or 180-day benefit waiting period. Premiums are based on the employee's age and salary. This plan is convertible if the employee plans to continue working and earning a salary. If the employee does not enroll in SLTD within 31 days of being hired, he may apply throughout the year by providing medical evidence of insurability. An employee must also provide medical evidence of insurability if he chooses to change his benefit waiting period from 180 to 90 days.

## Comparison of BLTD and SLTD Programs

| | BLTD | SLTD |
|---|---|---|
| **Eligibility** | Must be enrolled in a state health plan | Voluntary program |
| **Premium payment** | Employer pays monthly premium | Employee pays monthly premium |
| **Benefit waiting period** | 90-day waiting period | Employee chooses 90-day or 180-day waiting period |
| **Maximum benefit** | Monthly benefit is 62.5% of gross monthly salary*: $800 maximum with offsets | Monthly benefit is 65% of gross monthly salary*: $8,000 maximum with offsets |
| **Minimum benefit** | No minimum monthly benefit if offsets exceed 62.5% of gross monthly salary* | $100 per month minimum if offsets exceed liability |
| **Taxability of Benefits** | Yes | No |

**Gross monthly salary is based upon the rate of pay on January 1 preceding the disabling event.*

# Long Term Care Insurance

Long Term Care (LTC) is the day-to-day assistance that you need when you have a serious illness or disability that lasts for an extended period of time and you are not able to take care of yourself. Long Term Care includes a wide range of services that can be provided in your home, an adult day-care center, an assisted-living facility, a nursing home or a hospice. The Employee Insurance Program and Aetna, the state's Long Term Care program underwriter, offer you the Long Term Care Insurance Plan, with three plan options that are designed to protect your assets from depletion by the costs of long term care.

Full-time, permanent employees may enroll in the LTC Insurance Plan within 31 days of their hire date, without providing medical evidence of good health. Current full-time, permanent employees may enroll throughout the year, with approval of medical evidence of good health. Spouses, parents and parents-in-law of eligible employees may enroll throughout the year with approval of medical evidence of good health. A spouse, parent or parent-in-law is eligible to apply for enrollment even if the employee does not enroll. There is a ten percent discount in premiums if both the employee and his spouse enroll in the Service Reimbursement plans.

There are three LTC plans from which to choose: a disability plan and two service reimbursement plans. LTC plan premiums are on pages 36-38.

## LTC Plan Comparison

| | Disability Plan (Option #1) | Service Reimbursement Plan (Option #2) | Service Reimbursement Plan (Option #3) |
|---|---|---|---|
| ***Daily Benefit Amount*** **(DBA)** | $50 - $250 in $10 increments | $50 - $350 in $10 increments | $50 - $350 in $10 increments |
| **Lifetime Maximum Benefit Amount** | 5 years x DBA | 5 years x DBA | 5 years x DBA |
| **Nursing Facility or Hospice Care** | You receive 100% of your DBA | You receive your actual expenses, up to 100% of your DBA | You receive your actual expenses, up to 100% of your DBA |
| **Assisted Living Facility Care** | You receive 50% of your DBA | You receive your actual expenses, up to 100% of your DBA | You receive your actual expenses, up to 100% of your DBA |
| **Community-based Services** | You receive 50% of your DBA | You receive your actual expenses, up to 50% of your DBA | You receive your actual expenses, up to 100% of your DBA |
| **Informal Care** | You receive 50% of your DBA | 25% of your DBA up to 100 days each calendar year | 25% of your DBA up to 50 days each calendar year |
| **Alternate Care** | You receive 50% of your DBA | You receive your actual expenses, up to 50% of your DBA | You receive your actual expenses, up to 100% of your DBA |
| **Transitional Care** | You receive 50% of your DBA | You receive 3 times your DBA | You receive 3 times your DBA |
| **Informal Caregiver Training** | You receive 50% of your DBA | You receive the lesser of 100% of the actual expenses or 3 times your DBA | You receive the lesser of 100% of the actual expenses or 3 times your DBA |
| **Respite Care** | You receive 50% of your DBA | You receive your actual expenses, up to 50% of your DBA for 21 days each calendar year | You receive your actual expenses, up to 100% of your DBA for 21 days each calendar year |

# Vision Care Program

If you are a full-time or part-time employee, retiree, survivor or COBRA participant, you may take advantage of this program. Your dependents also are eligible. You do not have to subscribe to the State Health Plan or an HMO. Tell your provider you are a participant in the Vision Care Program. If you don't, you may not receive the discount. You may be required to show him some type of state-related identification to prove your eligibility.

Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60 for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may have to pay additional charges because that usually requires additional services.

Participating providers, including opticians, have agreed to give a 20 percent discount on all eyewear. The discount does not apply to disposable contact lenses. Participating providers are listed in the *Vision Care Program Directory* available on the EIP Web site at www.eip.sc.gov. The Vision Care Program is not associated with any state group health coverage. There are no claims to file and no reimbursement of fees.

# Late Entry and Making Coverage Changes

## Health Plans

If you and/or any of your eligible dependents do not enroll in the State Health Plan or an HMO within 31 days of eligibility, you will be considered a late entrant. You must wait until the next open enrollment period, held in October of odd-numbered years, or a special eligibility situation to enroll.

Enrollment and changes not made within 31 days of the date of hire or special eligibility situation cannot be made until the next open enrollment period or within 31 days of the next special eligibility situation. Coverage will be effective the following January 1 for changes made during open enrollment. Late entrants are subject to an 18-month pre-existing condition limitation period.

## Dental Plans

If you and/or any of your eligible dependents do not enroll in the State Dental Plan or Dental Plus within 31 days of eligibility, you must wait to enroll until the next open enrollment period or special eligibility situation. Coverage will be effective the following January 1 for changes made during open enrollment.

## Life Insurance

If you do not enroll in the Optional Life Insurance program within 31 days of your date of hire, you may apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. If you participate in the MoneyPlu$ Pretax Premium Feature, you may enroll only within 31 days of a special eligibility situation or during the annual enrollment period (Approval of medical evidence will be required, and coverage will be effective the following January 1.)

If you do not enroll your dependent spouse in the Dependent Life Insurance program within 31 days of your date of hire or a special eligibility situation, you can apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. Dependent children can be enrolled at any time throughout the year. Medical evidence of good health is not required.

## Supplemental Long Term Disability

If you do not enroll in the Supplemental Long Term Disability (SLTD) program when first eligible, or wish to decrease your benefit waiting period from 180 days to 90 days, you can do so throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval.

## Long Term Care

If you do not enroll in the LTC program when first eligible, or you wish to increase your coverage, you can apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. Your spouse, parents and parents-in-law may enroll throughout the year with approval of medical evidence of good health.

# Special Eligibility Situations

Coverage changes allowed due to a special eligibility situation must be made within 31 days of the date of occurrence. Special eligibility situations include:

- Marriage
- Birth, adoption or placement
- Divorce or legal separation
- Spouse becomes a state employee
- Spouse loses or gains employment
- Spouse retires
- Child turns age 19 and is not a full-time student
- Child age 19 through 24 becomes a full-time student
- Child is a full-time student who turns age 25
- Child becomes incapacitated before age 19 or before age 25 if a full-time student
- Death of a covered dependent and
- Child marries or is no longer principally dependent (more than 50 percent) on the employee for support and maintenance

**NOTE:** Employees **not** participating in the MoneyPlu$ Pretax Premium Feature may add Optional Life or increase the level of coverage year-round by providing medical evidence of good health. Employees not participating in the MoneyPlu$ Pretax Premium Feature may cancel Optional Life coverage or decrease the level of coverage effective the first of the month after the request.

Employees participating in the MoneyPlu$ Pretax Premium Feature are subject to MoneyPlu$ regulations and must make all requests within 31 days of a special eligibility situation or wait until an annual enrollment period to make changes.

# Changes you may Make Throughout the Year

## Adding/Changing Coverage

- You may enroll yourself and any eligible dependents in a health and/or dental plan within 31 days of a special eligibility situation. You may enroll only those dependents for whom the situation applies; you may not enroll other dependents for whom there is no special eligibility situation. You must file an NOE and documentation within 31 days of the event. Changes not made within 31 days of the special eligibility situation may not be made until the next open enrollment period or special eligibility situation.

- You may enroll yourself and/or your spouse in the Long Term Care (LTC) Insurance program, or increase your coverage level, upon approval of medical evidence of good health. For more information, contact Aetna, underwriter of the LTC program.

## Decreasing Coverage

- You may decrease your coverage level for health and dental if a spouse or dependent child becomes ineligible. Reasons for ineligibility include: spousal divorce or separation, child turns age 19 and is no longer a full-time student, child turns age 25, child marries or is no longer principally dependent (more than 50 percent) on the employee for maintenance and support. Changes should be requested within 31 days of ineligibility.

# Tips for Completing the NOE

Notice of Election (NOE) forms are available on the EIP Web site at www.eip.sc.gov. You may complete an NOE in one of two ways:

- *Interactively*—Type information directly into the spaces provided, print the completed form, sign it and submit it to your benefits administrator. Be careful making a selection when only one choice is allowed (such as choice of health plan). The interactive NOE has no safeguard that prevents more than one box from being checked.
- *Manually*—Print the form, fill it out by hand and submit it.

If you have Internet access, you are encouraged to use the interactive NOE on the EIP Web site. However, for those who do not have access to the Web, printed NOEs are available from your benefits administrator.

## General tips

- Use black ink when filling out the form by hand and when you sign it.
- Mark only the benefits in which you are enrolling.
- Review the NOE for accuracy, required documentation and for your signature.
- If you have any questions about completing the form, refer to the instructions on page 3 of the form or ask your benefits administrator.

## A. Administrative Information

Complete the information, except for the block, "BA USE ONLY." Be sure to check "Y" or "N" in the MoneyPlu$ block to indicate whether you want your health, dental and/or Optional Life insurance premiums to be deducted from your paycheck on a pretax basis. ❶

## B. Enrollee Information

Complete all relevant information, including your phone number at work and an e-mail address, if you have one.

- If you are completing the form online, a scrolling list of county code numbers appears for box #17. If you are completing the form manually, check with your benefits administrator for the correct county code number. ❷

## C. Medicare and other Coverage Information ❸

This information will be used to determine eligibility for enrolling in the Savings Plan as well as for coordination of benefits, including prescription drug benefits. If you or your dependents had other coverage within 62 days of the effective date of coverage indicated on the NOE, attach a certificate of coverage from the previous insurer to offset any pre-existing condition limitations.

- **MEDICARE PART A AND/OR PART B.** List yourself and any other covered dependents who are eligible for Part A or Part B of Medicare.
- **OTHER GROUP HEALTH COVERAGE, INCLUDING PHARMACY BENEFITS.** List any covered dependents who have other group health insurance coverage. This information is used for coordination of benefits and for updating EIP's records if a dependent has terminated other coverage. For example, if a dependent child has terminated other group coverage, you should indicate the termination date.

*(continued on page 28)*

# Sample Notice of Election Form (NOE)

## Page 1

**SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD**
**EMPLOYEE INSURANCE PROGRAM**
**ACTIVE NOTICE OF ELECTION (NOE)**

### A. ADMINISTRATIVE INFORMATION

CHECK ONE OF THE FOLLOWING:
☐ New Hire
☐ Transfer
☐ Change

TYPE OF CHANGE
☐ Enrollment
☐ Birth/Adoption
☐ Marriage
☐ Divorce
☐ Death
☐ Other (specify) _____
☐ Address
☐ Ineligible Dependent
☐ Involuntary loss of coverage
☐ Gain of other coverage
☐ Coordination of Benefits (See C)
Date of Occurrence: _____
SSN Change – Incorrect # _____ (attach copy of card)
Name Change – Prior _____

**BA USE ONLY**
Effective Date: _____
Group ID #: _____
Group Name: _____
☐ Permanent Part-time Employee (20 hours)

❶ **MONEYPLUS**
☐ Yes ☐ No

**HEALTH SAVINGS ACCOUNT (HSA)**
☐ Yes ☐ No
(For use with Savings Plan)

### B. ENROLLEE INFORMATION

| 1. Social Security Number | 2. Last Name | 3. Suffix | 4. First Name | 5. M.I. | 6. Date of Birth MM DD YYYY |
|---|---|---|---|---|---|
| ___-___-____ | | | | | |

| 7. Sex | 8. Marital Status | 9. Home Phone # | 10. Work Phone # | 11. E-mail Address |
|---|---|---|---|---|
| ☐ M ☐ F | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | | | |

| 12. Mailing Address | 13. Apt. | 14. City | 15. State | 16. ZIP Code | 17. County Code ❷ | 18. Annual Salary | 19. Date of Hire MM DD YYYY |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

❸

### C. MEDICARE AND OTHER COVERAGE INFORMATION

**LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR B OF MEDICARE.**

| 20. NAME | MEDICARE # | ENTITLED DUE TO | EFFECTIVE DATE PART A MM/DD/YYYY | EFFECTIVE DATE PART B MM/DD/YYYY |
|---|---|---|---|---|
| | ___-___-____-___ | ☐ AGE ☐ DISABILITY ☐ RENAL DISEASE | | |
| | ___-___-____-___ | ☐ AGE ☐ DISABILITY ☐ RENAL DISEASE | | |

**DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE OTHER GROUP HEALTH COVERAGE?** ☐ **YES** ☐ **NO**
**DOES THIS COVERAGE INCLUDE PHARMACY BENEFITS?** ☐ **YES** ☐ **NO**

| 21. NAME | INSURANCE COMPANY | POLICYHOLDER DATE OF BIRTH | EFFECTIVE DATE OF POLICY | TERMINATION DATE (IF APPLICABLE) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**IF YOU AND/OR YOUR DEPENDENTS HAVE HAD OTHER COVERAGE WITH ANOTHER CARRIER WITHIN 62 DAYS OF THIS REQUEST, PLEASE ATTACH A COPY OF YOUR CERTIFICATE OF HEALTH COVERAGE (HIPAA). THIS WILL ENSURE PROPER CREDIT FOR ANY PRE-EXISTING CONDITIONS, IF APPLICABLE.**

❹

### D. COVERAGE INFORMATION

22. **HEALTH** (Refuse or select **one** plan and **one** category.)

Plan
☐ Refuse
☐ Standard
☐ Savings (For non-Medicare Employees)
☐ TRICARE Supplement (For Non-Medicare Employees with TRICARE)
☐ HMO _____ Name

Category
☐ Enrollee
☐ Enrollee/Spouse
☐ Enrollee/Child(ren)
☐ Family

23. **DENTAL** (Select One)
☐ Refuse
☐ Enrollee
☐ Enrollee/Spouse
☐ Enrollee/Child
☐ Family

24. **DENTAL PLUS** (Select One)
☐ No (Refuse)
☐ Yes

25. **OPTIONAL LIFE** (Refuse or enter coverage level.)
☐ Refuse
☐ Coverage Level ❺
$_____
(Must be in increments of $10,000)

26. **DEPENDENT LIFE – SPOUSE** (Refuse or enter coverage level.)
☐ Refuse
☐ Coverage Level
$_____
(Must be in increments of $10,000)

27. **DEPENDENT LIFE – CHILD(REN)** (Select One)
☐ Refuse
☐ $10,000

28. **SUPPLEMENTAL LONG TERM DISABILITY** (Select One)
☐ Refuse/Cancel
☐ Plan One – 90 day benefit waiting period
☐ Plan Two – 180 day benefit waiting period

29. **BASIC LIFE/BASIC LTD** Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

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# Sample Notice of Election Form (NOE)
## Page 2



NAME:_____ SSN#:_____ GROUP #:_____

**E. DEPENDENT INFORMATION** ❻

**LIST SPOUSE AT ALL TIMES. LIST CHILDREN TO BE COVERED UNDER EITHER HEALTH/DENTAL OR DEPENDENT LIFE PLAN. IF THEY ARE NOT LISTED, THEY WILL NOT BE COVERED. IS YOUR SPOUSE A STATE EMPLOYEE OR EMPLOYED BY A STATE COVERED ENTITY? ☐ Yes ☐ No**

| ADD (A) OR DELETE (D) | 30. DEPENDENT SSN # | LAST NAME | FIRST NAME | SEX M/F | RELATION | DATE OF BIRTH MM DD YYYY | COMPLETE BELOW IF CHILD IS OVER 19 |
|---|---|---|---|---|---|---|---|
| | Spouse | | | | | | |
| | Child | | | | | | ☐ Full-time Student ☐ Incapacitated |
| | Child | | | | | | ☐ Full-time Student ☐ Incapacitated |
| | Child | | | | | | ☐ Full-time Student ☐ Incapacitated |
| | Child | | | | | | ☐ Full-time Student ☐ Incapacitated |

**IF FULL-TIME STUDENT WAS CHECKED AND YOU ARE ENROLLING THE DEPENDENT FOR THE FIRST TIME, ATTACH A FULL-TIME CERTIFICATION FROM THE SCHOOL. IF INCAPACITATED WAS CHECKED, ATTACH THE INCAPACITATED CHILD FORM.**

**F. BENEFICIARY INFORMATION – REQUIRED FOR BASIC LIFE AND OPTIONAL LIFE** ❼

| BASIC LIFE OR OPTIONAL LIFE (Check one or both.) | 31. LAST NAME * | FIRST NAME | SSN # | RELATIONSHIP | DATE OF BIRTH MM DD YYYY | PRIMARY OR CONTINGENT |
|---|---|---|---|---|---|---|
| ☐ BASIC LIFE ☐ OPTIONAL LIFE | | | | | | |
| ☐ BASIC LIFE ☐ OPTIONAL LIFE | | | | | | |
| ☐ BASIC LIFE ☐ OPTIONAL LIFE | | | | | | |

* IF BENEFICIARY IS AN ORGANIZATION OR TRUST, COMPLETE THE FOLLOWING :

ORGANIZATION/TRUST_____

ADDRESS_____

IF TRUST, DATE SIGNED_____

**UNLESS OTHERWISE PROVIDED HEREIN, IF TWO OR MORE BENEFICIARIES ARE NAMED, THE PROCEEDS SHALL BE PAID IN EQUAL SHARES TO THE NAMED SURVIVORS. CONTINGENT BENEFICIARIES HAVE NO RIGHTS UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED.**

**32. CERTIFICATION:** I have read this NOE and made the authorizations herein and have selected the coverage noted. I have provided social security numbers and documentation establishing my dependent's eligibility for the plan(s) selected. **I understand that I may only cancel my coverage and/or my dependent's coverage during an open enrollment period every two years, unless otherwise provided for in the Plan. Should I refuse health coverage or fail to enroll all eligible dependents in health coverage when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period, unless otherwise provided in the Plan. I also understand that I will be able to add or cancel dental coverage only during the open enrollment period every two years unless otherwise provided in the Plan.** ❽

I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the state reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan.

**AUTHORIZATION:** I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary when necessary for enrollment. I hereby authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process all claims for any benefits.

Employee Signature: _____ Date:_____

33. I hereby attest that the employee meets eligibility requirements of plan, proper premiums are being collected, form is complete and accurate, and all required documentation is attached in order to process NOE form.

Benefits Administrator Signature: _____ Date: _____

**THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.**

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# Tips for Completing the NOE (continued)

## D. Coverage Information

You select or refuse your plans and coverage in this section.

- If you choose an **HMO** (with or without the point-of-service option), write the full name ❹ of the HMO: *Companion HMO, CIGNA HMO* or *MUSC Options.* The HMO that you choose will work directly with you in designating a primary care physician.
- You may enroll in **Optional Life** for up to three times your salary, rounded down to the nearest $10,000. You may also enroll for additional coverage by providing medical evidence ❺ of good health. If you choose to enroll for more than three times your salary, you will need to complete an NOE indicating your chosen level of coverage and a Personal Health Statement (PHS) from The Hartford. The Personal Health Statement is available on the EIP Web site at www.eip.sc.gov or from your benefits administrator.

## E. Dependent Information ❻

- A checkbox is located at the start of this section to indicate whether your spouse is also employed by a participating employer.
- Be sure to **include the dependent's Social Security number.**
- Indicate whether any dependent child who is older than 19 is a full-time student or is incapacitated and attach the appropriate documentation as required, such as a letter of certification from the academic institution or an Incapacitated Child Certification Form.

## F. Beneficiary Information ❼

In this section, you designate any beneficiaries to receive your life insurance, in the event of your death. If more than one beneficiary is designated, they will share equally, unless you specify otherwise, by indicating percentages to each.

- Indicate whether they are primary beneficiaries or contingent beneficiaries. Contingent beneficiaries are paid only if any and all primary beneficiaries have predeceased the employee.
- If you are naming an organization or trust as beneficiary, you must complete the additional information requested.
- ❽ Read the certification and authorization before you sign the form. Return the completed form to your benefits administrator.

# Comparison of Health Plan

| Plan | SHP Savings Plan | | SHP Standard Plan | |
|---|---|---|---|---|
| **Availability** | Coverage Worldwide | | Coverage Worldwide | |
| **Active Employee Monthly Premiums**[2]<br>*Employees Only*<br>*Employee/Spouse*<br>*Employee/Children*<br>*Full Family* | **$ 9.28**<br>**$ 72.56**<br>**$ 20.28**<br>**$108.56** | | **$ 93.46**<br>**$237.50**<br>**$142.46**<br>**$294.58** | |
| **Annual Deductible**<br>*Single*<br>*Family* | **$3,000**<br>**$6,000** | | **$350**<br>**$700** | |
| **Coinsurance** | **In-network**<br>Plan Pays<br>80%<br>You Pay 20% | **Out-of-network**<br>Plan Pays<br>60%<br>You pay 40% | **In-network**<br>Plan Pays<br>80%<br>You Pay 20% | **Out-of-network**<br>Plan Pays<br>60%<br>You Pay 40 % |
| **Coinsurance Maximum**<br>*Single*<br>*Family* | **$2,000**<br>**$4,000**<br>**(excludes deductible)** | NONE | **$2,000**<br>**$4,000**<br>**(excludes deductible)** | **$4,000**<br>**$8,000**<br>**(excludes deductible)** |
| **Physicians Office Visits** | Chiropractic payments limited to $500 a year per person<br>No per-visit deductible or copayments | | **$10 per visit deductible then:** | |
| | **In-network**<br>Plan Pays<br>80%<br>You Pay 20% | **Out-of-network**<br>Plan Pays<br>60%<br>You Pay 40% | **In-network**<br>Plan Pays<br>80%<br>You Pay 20% | **Out-of-network**<br>Plan Pays<br>60%<br>You Pay 40% |
| **Hospitalization/Emergency Care** | No per-occurrence deductibles or copayments | | Outpatient hospital: **$75** per-occurrence deductible<br>Emergency care: **$125** per occurrence deductible | |
| **Prescription Drugs** | Participating pharmacies and mail order only: You pay the State Health Plan's allowable cost until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable cost; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable cost. | | Participating pharmacies only:<br>**$10** generic<br>**$25** preferred brand<br>**$40** non-preferred brand<br>(up to 31-day supply)<br>Mail order (up to 90-day supply): **$25** generic, **$62** preferred brand, **$100** non-preferred brand<br>Out of pocket max: **$2,500** | |

[1]This table is for comparison purposes only.

[2]Rates for local subdivisions may vary. To verify your rates, contact your benefits office.

[3]There will be no copayment for services performed at MUSC outpatient facilities.

# Benefits Offered for 2005[1]

| Companion HMO | CIGNA HMO | MUSC Options | |
|---|---|---|---|
| Available in all South Carolina counties | Available in all South Carolina counties **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda* | Available in these South Carolina counties: *Berkeley, Charleston, Colleton and Dorchester* counties | |
| **$101.58**<br>**$309.24**<br>**$226.36**<br>**$464.00** | **$ 97.80**<br>**$296.66**<br>**$216.36**<br>**$445.34** | **$ 99.02**<br>**$288.40**<br>**$190.34**<br>**$374.00** | |
| **$250**<br>**$500** | NONE | **In-network**<br>NONE | **Out-of-network**<br>**$300**<br>**$900** |
| HMO pays 90% after copays<br>You pay 10% | HMO pays 80% after copays<br>You pay 20% | **In-network**<br>HMO pays 100% after copays | **Out-of-network**<br>HMO pays 60% of allowance<br>You pay 40% |
| **$1,500**<br>**$3,000**<br>**(excludes deductible)** | **$3,000**<br>**$6,000**<br>**(includes inpatient, outpatient, copays and coinsurance)** | N/A | **$3,000**<br>**$9,000**<br>**(excludes deductibles)** |
| **$15** PCP copayment<br>**$15** OB/GYN well woman exam<br>**$25** specialist copay | **$20** PCP copayment<br>**$40** OB/GYN well woman exam<br>**$40** specialist copay | **$15** PCP copay<br>**$15** OB/GYN well woman exam<br>**$25** specialist copay with referral<br>**$45** specialist copay without referral | HMO pays 60% of allowance after annual deductible<br>You pay 40%<br><br>No preventive care benefits out-of-network |
| Inpatient: **$200** copay<br>Outpatient: **$75** copay/first 3 visits<br>Emergency Care: **$100** copay<br>HMO pays 90% after copays<br>You pay 10%<br>**$35** urgent care copay, then HMO pays 100% | Inpatient: **$500** copay<br>Outpatient facility: **$250** copay<br>Emergency care: **$100** copay | Inpatient: **$300** copay<br>Outpatient Facility: **$100**[3] copay<br>Emergency Care: **$100** copay<br>**$35** urgent care copay | HMO pays 60% of allowance after annual deductible<br>You pay 40%<br><br>Emergency care: **$100** copay |
| Participating Pharmacies only<br>**$8** generic<br>**$25** preferred brand<br>**$40** non-preferred brand<br>**$75** specialty pharmaceuticals (31-day supply)<br>Mail order (Up to 90-day supply): **$16** generic, **$50** preferred brand, **$80** non-preferred brand | Participating pharmacies only:<br>**$7** generic<br>**$25** preferred brand<br>**$50** non-preferred brand (up to 30-day supply)<br>Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand | Participating pharmacies only:<br>**$10** generic<br>**$25** preferred brand<br>**$40** non-preferred brand (31-day supply)<br>Mail order (90-day supply):<br>**$15** generic, **$50** preferred brand, **$80** non-preferred brand | |

# 2005 Premiums

## 2005 Monthly Employer Contributions[1]

| EMPLOYER | | | | | |
|---|---|---|---|---|---|
| | Health | TRICARE Supplement | Dental | Life | LTD |
| Employee Only | 221.58 | 63.50 | 11.71 | .35 | 3.23 |
| Employee/Spouse | 431.60 | 122.50 | 11.71 | .35 | 3.23 |
| Employee/Child | 312.60 | 122.50 | 11.71 | .35 | 3.23 |
| Full Family | 503.46 | 163.50 | 11.71 | .35 | 3.23 |

*[1]Rates for employers of local subdivisions may vary. To verify your employer's rates, contact your benefits office.*

## 2005 Active Employee Monthly Premiums[2]

| HEALTH EMPLOYEE | | | | | | |
|---|---|---|---|---|---|---|
| | Savings | Standard | Companion | CIGNA | MUSC Options | TRICARE Supplement |
| Employee Only | 9.28 | 93.46 | 101.58 | 97.80 | 99.02 | 0.00 |
| Employee/Spouse | 72.56 | 237.50 | 309.24 | 296.66 | 288.40 | 0.00 |
| Employee/Child | 20.28 | 142.46 | 226.36 | 216.36 | 190.34 | 0.00 |
| Full Family | 108.56 | 294.58 | 464.00 | 445.34 | 374.00 | 0.00 |

*[2]Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.*

## 2005 Supplemental LTD Monthly Premium Rate

| SUPPLEMENTAL LTD | | |
|---|---|---|
| Age | Plan One: 90 Days | Plan Two: 180 Days |
| < 31 | 0.00077 | 0.00059 |
| 31 – 40 | 0.00105 | 0.00081 |
| 41 – 50 | 0.00210 | 0.00161 |
| 51 – 60 | 0.00423 | 0.00326 |
| 61 – 65 | 0.00509 | 0.00392 |
| > 65 | 0.00621 | 0.00478 |

**STEPS TO CALCULATE SLTD MONTHLY PREMIUM**

1. Always select floating decimal (F) on your calculator.
2. Divide gross annual salary by 12 to determine monthly salary.
3. Multiply monthly salary by rate factor from table.
4. Drop digits to right of 2 decimal places; do not round.
5. If number is even, this is the monthly premium.

## 2005 Active Employee Monthly Dental Premiums

| DENTAL EMPLOYEE | | |
|---|---|---|
| | State Dental Plan | Dental Plus |
| Employee Only | 0.00 | 17.50 |
| Employee/Spouse | 7.64 | 33.14 |
| Employee/Child | 13.72 | 36.16 |
| Full Family | 21.34 | 51.80 |

# 2005 MoneyPlu$ Monthly Administrative Fees

| | |
|---|---|
| Pretax Group Insurance Premium Feature[1] | $0.12 per month |
| Dependent Care Spending Account[1] | $2.50 per month |
| Medical Spending Account or limited-use MSA[1] | $2.50 per month |
| EZ REIMBURSE® MasterCard®[2] | $20 per year |

| Health Savings Account[3] |
|---|
| $20 per year or $2 per month (your choice) |
| 50 cents per check if you are reimbursed by check. |
| No charge if you use your VISA® debit card. |

*[1]These fees are deducted from your paycheck before taxes.*
*[2]The fee for this optional debit card will be deducted from your Medical Spending Account.*
*[3]There may be additional fees for other services. All fees are deducted from your HSA.*

# 2005 Optional Life, Dependent Life Spouse Monthly Premiums

## Monthly Rates for Employees through age 69

| Employee's Age | <35 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 |
|---|---|---|---|---|---|---|---|---|
| Coverage | | | | | | | | |
| $10,000 | $ 0.72 | $ 0.84 | $ 1.34 | $ 1.86 | $ 2.88 | $ 4.50 | $ 6.90 | $10.30 |
| $20,000 | 1.44 | 1.68 | 2.68 | 3.72 | 5.76 | 9.00 | 13.80 | 20.60 |
| $30,000 | 2.16 | 2.52 | 4.02 | 5.58 | 8.64 | 13.50 | 20.70 | 30.90 |
| $40,000 | 2.88 | 3.36 | 5.36 | 7.44 | 11.52 | 18.00 | 27.60 | 41.20 |
| $50,000 | 3.60 | 4.20 | 6.70 | 9.30 | 14.40 | 22.50 | 34.50 | 51.50 |
| $60,000 | 4.32 | 5.04 | 8.04 | 11.16 | 17.28 | 27.00 | 41.40 | 61.80 |
| $70,000 | 5.04 | 5.88 | 9.38 | 13.02 | 20.16 | 31.50 | 48.30 | 72.10 |
| $80,000 | 5.76 | 6.72 | 10.72 | 14.88 | 23.04 | 36.00 | 55.20 | 82.40 |
| $90,000 | 6.48 | 7.56 | 12.06 | 16.74 | 25.92 | 40.50 | 62.10 | 92.70 |
| $100,000 | 7.20 | 8.40 | 13.40 | 18.60 | 28.80 | 45.00 | 69.00 | 103.00 |
| $110,000 | 7.92 | 9.24 | 14.74 | 20.46 | 31.68 | 49.50 | 75.90 | 113.30 |
| $120,000 | 8.64 | 10.08 | 16.08 | 22.32 | 34.56 | 54.00 | 82.80 | 123.60 |
| $130,000 | 9.36 | 10.92 | 17.42 | 24.18 | 37.44 | 58.50 | 89.70 | 133.90 |
| $140,000 | 10.08 | 11.76 | 18.76 | 26.04 | 40.32 | 63.00 | 96.60 | 144.20 |
| $150,000 | 10.80 | 12.60 | 20.10 | 27.90 | 43.20 | 67.50 | 103.50 | 154.50 |
| $160,000 | 11.52 | 13.44 | 21.44 | 29.76 | 46.08 | 72.00 | 110.40 | 164.80 |
| $170,000 | 12.24 | 14.28 | 22.78 | 31.62 | 48.96 | 76.50 | 117.30 | 175.10 |
| $180,000 | 12.96 | 15.12 | 24.12 | 33.48 | 51.84 | 81.00 | 124.20 | 185.40 |
| $190,000 | 13.68 | 15.96 | 25.46 | 35.34 | 54.72 | 85.50 | 131.10 | 195.70 |
| $200,000 | 14.40 | 16.80 | 26.80 | 37.20 | 57.60 | 90.00 | 138.00 | 206.00 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| $210,000 | 15.12 | 17.64 | 28.14 | 39.06 | 60.48 | 94.50 | 144.90 | 216.30 |
| $220,000 | 15.84 | 18.48 | 29.48 | 40.92 | 63.36 | 99.00 | 151.80 | 226.60 |
| $230,000 | 16.56 | 19.32 | 30.82 | 42.78 | 66.24 | 103.50 | 158.70 | 236.90 |
| $240,000 | 17.28 | 20.16 | 32.16 | 44.64 | 69.12 | 108.00 | 165.60 | 247.20 |
| $250,000 | 18.00 | 21.00 | 33.50 | 46.50 | 72.00 | 112.50 | 172.50 | 257.50 |
| $260,000 | 18.72 | 21.84 | 34.84 | 48.36 | 74.88 | 117.00 | 179.40 | 267.80 |
| $270,000 | 19.44 | 22.68 | 36.18 | 50.22 | 77.76 | 121.50 | 186.30 | 278.10 |
| $280,000 | 20.16 | 23.52 | 37.52 | 52.08 | 80.64 | 126.00 | 193.20 | 288.40 |
| $290,000 | 20.88 | 24.36 | 38.86 | 53.94 | 83.52 | 130.50 | 200.10 | 298.70 |
| $300,000 | 21.60 | 25.20 | 40.20 | 55.80 | 86.40 | 135.00 | 207.00 | 309.00 |
| $310,000 | 22.32 | 26.04 | 41.54 | 57.66 | 89.28 | 139.50 | 213.90 | 319.30 |
| $320,000 | 23.04 | 26.88 | 42.88 | 59.52 | 92.16 | 144.00 | 220.80 | 329.60 |
| $330,000 | 23.76 | 27.72 | 44.22 | 61.38 | 95.04 | 148.50 | 227.70 | 339.90 |
| $340,000 | 24.48 | 28.56 | 45.56 | 63.24 | 97.92 | 153.00 | 234.60 | 350.20 |
| $350,000 | 25.20 | 29.40 | 46.90 | 65.10 | 100.80 | 157.50 | 241.50 | 360.50 |
| $360,000 | 25.92 | 30.24 | 48.24 | 66.96 | 103.68 | 162.00 | 248.40 | 370.80 |
| $370,000 | 26.64 | 31.08 | 49.58 | 68.82 | 106.56 | 166.50 | 255.30 | 381.10 |
| $380,000 | 27.36 | 31.92 | 50.92 | 70.68 | 109.44 | 171.00 | 262.20 | 391.40 |
| $390,000 | 28.08 | 32.76 | 52.26 | 72.54 | 112.32 | 175.50 | 269.10 | 401.70 |
| $400,000 | 28.80 | 33.60 | 53.60 | 74.40 | 115.20 | 180.00 | 276.00 | 412.00 |
| $410,000 | 29.52 | 34.44 | 54.94 | 76.26 | 118.08 | 184.50 | 282.90 | 422.30 |
| $420,000 | 30.24 | 35.28 | 56.28 | 78.12 | 120.96 | 189.00 | 289.80 | 432.60 |
| $430,000 | 30.96 | 36.12 | 57.62 | 79.98 | 123.84 | 193.50 | 296.70 | 442.90 |
| $440,000 | 31.68 | 36.96 | 58.96 | 81.84 | 126.72 | 198.00 | 303.60 | 453.20 |
| $450,000 | 32.40 | 37.80 | 60.30 | 83.70 | 129.60 | 202.50 | 310.50 | 463.50 |
| $460,000 | 33.12 | 38.64 | 61.64 | 85.56 | 132.48 | 207.00 | 317.40 | 473.80 |
| $470,000 | 33.84 | 39.48 | 62.98 | 87.42 | 135.36 | 211.50 | 324.30 | 484.10 |
| $480,000 | 34.56 | 40.32 | 64.32 | 89.28 | 138.24 | 216.00 | 331.20 | 494.40 |
| $490,000 | 35.28 | 41.16 | 65.66 | 91.14 | 141.12 | 220.50 | 338.10 | 504.70 |
| $500,000 | 36.00 | 42.00 | 67.00 | 93.00 | 144.00 | 225.00 | 345.00 | 515.00 |

## Monthly Rates for Employees age 70 and Older

| **Employee's Age** | | **70-74** | | **75-79** | | **80+** |
|---|---|---|---|---|---|---|
| **Coverage** | **Coverage** | | **Coverage** | | | **Coverage** |
| $10,000 | $6,500 | $ 10.82 | $4,200 | $ 11.36 | $3,170 | $ 14.34 |
| $20,000 | $13,000 | 21.62 | $8,400 | 22.76 | $6,340 | 28.68 |
| $30,000 | $19,500 | 32.46 | $12,600 | 34.12 | $9,510 | 43.00 |
| $40,000 | $26,000 | 43.26 | $16,800 | 45.48 | $12,680 | 57.34 |
| $50,000 | $32,500 | 54.08 | $21,000 | 56.88 | $15,850 | 71.66 |
| $60,000 | $39,000 | 64.90 | $25,200 | 68.24 | $19,020 | 86.02 |
| $70,000 | $45,500 | 75.70 | $29,400 | 79.62 | $22,190 | 100.34 |
| $80,000 | $52,000 | 86.54 | $33,600 | 91.00 | $25,360 | 114.68 |
| $90,000 | $58,500 | 97.34 | $37,800 | 102.36 | $28,530 | 129.02 |
| $100,000 | $65,000 | 108.16 | $42,000 | 113.74 | $31,700 | 143.36 |

| | | | | | | |
|---|---|---|---|---|---|---|
| $110,000 | $71,500 | 118.98 | $46,200 | 125.10 | $34,870 | 157.68 |
| $120,000 | $78,000 | 129.78 | $50,400 | 136.48 | $38,040 | 172.02 |
| $130,000 | $84,500 | 140.62 | $54,600 | 147.86 | $41,210 | 186.34 |
| $140,000 | $91,000 | 151.42 | $58,800 | 159.22 | $44,380 | 200.70 |
| $150,000 | $97,500 | 162.24 | $63,000 | 170.60 | $47,550 | 215.02 |
| $160,000 | $104,000 | 173.06 | $67,200 | 181.98 | $50,720 | 229.36 |
| $170,000 | $110,500 | 183.86 | $71,400 | 193.34 | $53,890 | 243.68 |
| $180,000 | $117,000 | 194.70 | $75,600 | 204.72 | $57,060 | 258.04 |
| $190,000 | $123,500 | 205.50 | $79,800 | 216.10 | $60,230 | 272.36 |
| $200,000 | $130,000 | 216.32 | $84,000 | 227.46 | $63,400 | 286.70 |
| $210,000 | $136,500 | 227.14 | $88,200 | 238.86 | $66,570 | 301.02 |
| $220,000 | $143,000 | 237.94 | $92,400 | 250.22 | $69,740 | 315.36 |
| $230,000 | $149,500 | 248.76 | $96,600 | 261.58 | $72,910 | 329.70 |
| $240,000 | $156,000 | 259.58 | $100,800 | 272.98 | $76,080 | 344.02 |
| $250,000 | $162,500 | 270.40 | $105,000 | 284.34 | $79,250 | 358.38 |
| $260,000 | $169,000 | 281.22 | $109,200 | 295.70 | $82,420 | 372.70 |
| $270,000 | $175,500 | 292.02 | $113,400 | 307.10 | $85,590 | 387.04 |
| $280,000 | $182,000 | 302.86 | $117,600 | 318.46 | $88,760 | 401.36 |
| $290,000 | $188,500 | 313.66 | $121,800 | 328.82 | $91,930 | 415.72 |
| $300,000 | $195,000 | 324.48 | $126,000 | 341.22 | $95,100 | 430.04 |
| $310,000 | $201,500 | 335.30 | $130,200 | 352.58 | $98,270 | 444.38 |
| $320,000 | $208,000 | 346.10 | $134,400 | 363.96 | $101,440 | 458.70 |
| $330,000 | $214,500 | 356.94 | $138,600 | 375.34 | $104,610 | 473.06 |
| $340,000 | $221,000 | 367.74 | $142,800 | 386.70 | $107,780 | 487.38 |
| $350,000 | $227,500 | 378.56 | $147,000 | 398.08 | $110,950 | 501.72 |
| $360,000 | $234,000 | 389.38 | $151,200 | 409.44 | $114,120 | 516.04 |
| $370,000 | $240,500 | 400.20 | $155,400 | 420.82 | $117,290 | 530.40 |
| $380,000 | $247,000 | 411.00 | $159,600 | 432.20 | $120,460 | 544.72 |
| $390,000 | $253,500 | 421.82 | $163,800 | 443.56 | $123,630 | 559.06 |
| $400,000 | $260,000 | 432.64 | $168,000 | 454.94 | $127,000 | 573.38 |
| $410,000 | $266,500 | 443.46 | $172,200 | 466.32 | $129,970 | 587.72 |
| $420,000 | $273,000 | 454.26 | $176,400 | 477.68 | $133,140 | 602.06 |
| $430,000 | $279,500 | 465.08 | $180,600 | 489.06 | $136,310 | 616.38 |
| $440,000 | $286,000 | 475.90 | $184,800 | 500.44 | $139,480 | 630.74 |
| $450,000 | $292,500 | 486.72 | $189,000 | 511.80 | $142,650 | 645.06 |
| $460,000 | $299,000 | 497.54 | $193,200 | 523.20 | $145,820 | 659.40 |
| $470,000 | $305,500 | 508.34 | $197,400 | 534.56 | $148,990 | 673.72 |
| $480,000 | $312,000 | 519.18 | $201,600 | 545.92 | $152,160 | 688.08 |
| $490,000 | $318,500 | 529.98 | $205,800 | 557.32 | $155,330 | 702.40 |
| $500,000 | $325,000 | 540.80 | $210,000 | 568.68 | $158,500 | 716.74 |

## 2005 Dependent Life Child Monthly Premium

Monthly premium for Dependent Life child coverage is $1.32, regardless of the number of children covered. The coverage level is $10,000.

# 2005 Long Term Care Monthly Premiums* - Option 1

## (Disability Model)

| 2005 LONG TERM CARE RATES* | | | | | | | |
|---|---|---|---|---|---|---|---|
| OPTION 1 (Disability) | | | | | | | |
| Return of Contribution Excluded | | | | Return of Contributions Included | | | |
| AGE | Per $10 | AGE | Per $10 | AGE | Per $10 | AGE | Per $10 |
| 20 | 0.20 | 60 | 6.64 | 20 | 0.22 | 60 | 7.20 |
| 21 | 0.24 | 61 | 7.18 | 21 | 0.24 | 61 | 7.72 |
| 22 | 0.26 | 62 | 7.76 | 22 | 0.26 | 62 | 8.28 |
| 23 | 0.28 | 63 | 8.38 | 23 | 0.28 | 63 | 8.90 |
| 24 | 0.30 | 64 | 9.08 | 24 | 0.32 | 64 | 9.56 |
| 25 | 0.34 | 65 | 9.84 | 25 | 0.36 | 65 | 10.26 |
| 26 | 0.38 | 66 | 10.66 | 26 | 0.40 | 66 | 11.16 |
| 27 | 0.40 | 67 | 11.54 | 27 | 0.42 | 67 | 12.16 |
| 28 | 0.44 | 68 | 12.52 | 28 | 0.46 | 68 | 13.28 |
| 29 | 0.48 | 69 | 13.56 | 29 | 0.52 | 69 | 14.48 |
| 30 | 0.54 | 70 | 14.72 | 30 | 0.56 | 70 | 15.84 |
| 31 | 0.58 | 71 | 15.98 | 31 | 0.62 | 71 | 17.34 |
| 32 | 0.62 | 72 | 17.32 | 32 | 0.68 | 72 | 19.00 |
| 33 | 0.70 | 73 | 18.80 | 33 | 0.74 | 73 | 20.82 |
| 34 | 0.76 | 74 | 20.38 | 34 | 0.82 | 74 | 22.88 |
| 35 | 0.82 | 75 | 22.16 | 35 | 0.90 | 75 | 25.14 |
| 36 | 0.90 | 76 | 24.08 | 36 | 0.98 | 76 | 27.68 |
| 37 | 0.98 | 77 | 26.12 | 37 | 1.08 | 77 | 30.46 |
| 38 | 1.08 | 78 | 28.30 | 38 | 1.18 | 78 | 33.50 |
| 39 | 1.18 | 79 | 30.44 | 39 | 1.30 | 79 | 36.60 |
| 40 | 1.30 | 80 | 32.52 | 40 | 1.42 | 80 | 39.76 |
| 41 | 1.40 | 81 | 34.44 | 41 | 1.56 | 81 | 42.84 |
| 42 | 1.54 | 82 | 36.14 | 42 | 1.72 | 82 | 45.82 |
| 43 | 1.68 | 83 | 37.60 | 43 | 1.88 | 83 | 48.60 |
| 44 | 1.84 | 84 | 38.92 | 44 | 2.06 | 84 | 51.30 |
| 45 | 2.00 | 85 | 40.12 | 45 | 2.24 | 85 | 53.92 |
| 46 | 2.18 | 86 | 41.20 | 46 | 2.44 | 86 | 56.46 |
| 47 | 2.36 | 87 | 42.18 | 47 | 2.64 | 87 | 58.92 |
| 48 | 2.56 | 88 | 43.02 | 48 | 2.88 | 88 | 61.32 |
| 49 | 2.78 | 89 | 43.84 | 49 | 3.10 | 89 | 63.80 |
| 50 | 3.02 | 90+ | 44.66 | 50 | 3.36 | 90+ | 66.46 |
| 51 | 3.24 | | | 51 | 3.66 | | |
| 52 | 3.52 | | | 52 | 3.94 | | |
| 53 | 3.82 | | | 53 | 4.26 | | |
| 54 | 4.14 | | | 54 | 4.62 | | |
| 55 | 4.48 | | | 55 | 4.98 | | |
| 56 | 4.84 | | | 56 | 5.38 | | |
| 57 | 5.26 | | | 57 | 5.80 | | |
| 58 | 5.68 | | | 58 | 6.24 | | |
| 59 | 6.14 | | | 59 | 6.70 | | |

**Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.*

# 2005 Long Term Care Monthly Premiums* - Option 2

## (Service Reimbursement - 50% Home Health)

| 2005 LONG TERM CARE RATES* | | | | | | | |
|---|---|---|---|---|---|---|---|
| OPTION 2 (Service Reimbursement)** | | | | | | | |
| Return of Contribution Excluded | | | | Return of Contributions Included | | | |
| AGE | Per $10 | AGE | Per $10 | AGE | Per $10 | AGE | Per $10 |
| 20 | 0.28 | 60 | 5.02 | 20 | 0.28 | 60 | 5.14 |
| 21 | 0.28 | 61 | 5.52 | 21 | 0.30 | 61 | 5.66 |
| 22 | 0.30 | 62 | 6.06 | 22 | 0.32 | 62 | 6.22 |
| 23 | 0.34 | 63 | 6.70 | 23 | 0.34 | 63 | 6.86 |
| 24 | 0.36 | 64 | 7.40 | 24 | 0.36 | 64 | 7.54 |
| 25 | 0.38 | 65 | 8.06 | 25 | 0.38 | 65 | 8.22 |
| 26 | 0.40 | 66 | 8.90 | 26 | 0.42 | 66 | 9.10 |
| 27 | 0.44 | 67 | 9.90 | 27 | 0.46 | 67 | 10.16 |
| 28 | 0.48 | 68 | 10.70 | 28 | 0.50 | 68 | 11.00 |
| 29 | 0.54 | 69 | 11.60 | 29 | 0.56 | 69 | 11.96 |
| 30 | 0.58 | 70 | 12.62 | 30 | 0.58 | 70 | 13.04 |
| 31 | 0.62 | 71 | 13.76 | 31 | 0.64 | 71 | 14.28 |
| 32 | 0.68 | 72 | 15.04 | 32 | 0.70 | 72 | 15.68 |
| 33 | 0.72 | 73 | 16.44 | 33 | 0.74 | 73 | 17.26 |
| 34 | 0.78 | 74 | 18.02 | 34 | 0.80 | 74 | 19.06 |
| 35 | 0.84 | 75 | 19.78 | 35 | 0.88 | 75 | 21.08 |
| 36 | 0.90 | 76 | 21.74 | 36 | 0.92 | 76 | 23.38 |
| 37 | 0.98 | 77 | 23.94 | 37 | 1.00 | 77 | 26.04 |
| 38 | 1.04 | 78 | 26.34 | 38 | 1.06 | 78 | 29.00 |
| 39 | 1.10 | 79 | 28.92 | 39 | 1.14 | 79 | 32.26 |
| 40 | 1.18 | 80 | 31.48 | 40 | 1.20 | 80 | 35.62 |
| 41 | 1.24 | 81 | 33.80 | 41 | 1.28 | 81 | 38.80 |
| 42 | 1.32 | 82 | 36.02 | 42 | 1.36 | 82 | 42.00 |
| 43 | 1.40 | 83 | 38.44 | 43 | 1.46 | 83 | 45.60 |
| 44 | 1.48 | 84 | 40.60 | 44 | 1.54 | 84 | 49.14 |
| 45 | 1.58 | 85 | 42.46 | 45 | 1.66 | 85 | 52.48 |
| 46 | 1.68 | 86 | 44.54 | 46 | 1.74 | 86 | 56.34 |
| 47 | 1.78 | 87 | 46.30 | 47 | 1.84 | 87 | 60.02 |
| 48 | 1.90 | 88 | 47.74 | 48 | 1.98 | 88 | 63.56 |
| 49 | 2.04 | 89 | 48.94 | 49 | 2.12 | 89 | 66.96 |
| 50 | 2.16 | 90+ | 49.70 | 50 | 2.26 | 90+ | 69.80 |
| 51 | 2.32 | | | 51 | 2.40 | | |
| 52 | 2.46 | | | 52 | 2.58 | | |
| 53 | 2.70 | | | 53 | 2.80 | | |
| 54 | 2.94 | | | 54 | 3.04 | | |
| 55 | 3.20 | | | 55 | 3.30 | | |
| 56 | 3.48 | | | 56 | 3.62 | | |
| 57 | 3.82 | | | 57 | 3.94 | | |
| 58 | 4.16 | | | 58 | 4.32 | | |
| 59 | 4.58 | | | 59 | 4.72 | | |

**Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.*
***Includes 50 percent home health care benefit.*

# 2005 Long Term Care Monthly Premiums* - Option 3

## (Service Reimbursement - 100% Home Health)

| 2005 LONG TERM CARE RATES* | | | | | | | |
|---|---|---|---|---|---|---|---|
| OPTION 3 (Service Reimbursement)** | | | | | | | |
| Return of Contribution Excluded | | | | Return of Contributions Included | | | |
| AGE | Per $10 | AGE | Per $10 | AGE | Per $10 | AGE | Per $10 |
| 20 | 0.42 | 60 | 6.90 | 20 | 0.42 | 60 | 7.06 |
| 21 | 0.44 | 61 | 7.56 | 21 | 0.44 | 61 | 7.76 |
| 22 | 0.46 | 62 | 8.32 | 22 | 0.46 | 62 | 8.48 |
| 23 | 0.48 | 63 | 9.18 | 23 | 0.50 | 63 | 9.34 |
| 24 | 0.52 | 64 | 10.14 | 24 | 0.52 | 64 | 10.30 |
| 25 | 0.56 | 65 | 11.00 | 25 | 0.58 | 65 | 11.18 |
| 26 | 0.60 | 66 | 12.14 | 26 | 0.62 | 66 | 12.36 |
| 27 | 0.66 | 67 | 13.48 | 27 | 0.68 | 67 | 13.76 |
| 28 | 0.72 | 68 | 14.58 | 28 | 0.72 | 68 | 14.90 |
| 29 | 0.78 | 69 | 15.78 | 29 | 0.80 | 69 | 16.20 |
| 30 | 0.84 | 70 | 17.14 | 30 | 0.86 | 70 | 17.62 |
| 31 | 0.90 | 71 | 18.66 | 31 | 0.92 | 71 | 19.26 |
| 32 | 0.98 | 72 | 20.34 | 32 | 1.00 | 72 | 21.08 |
| 33 | 1.06 | 73 | 22.20 | 33 | 1.10 | 73 | 23.16 |
| 34 | 1.14 | 74 | 24.30 | 34 | 1.18 | 74 | 25.50 |
| 35 | 1.24 | 75 | 26.56 | 35 | 1.28 | 75 | 28.14 |
| 36 | 1.32 | 76 | 29.18 | 36 | 1.36 | 76 | 31.18 |
| 37 | 1.40 | 77 | 32.06 | 37 | 1.44 | 77 | 34.62 |
| 38 | 1.48 | 78 | 35.20 | 38 | 1.54 | 78 | 38.48 |
| 39 | 1.60 | 79 | 38.56 | 39 | 1.66 | 79 | 42.70 |
| 40 | 1.70 | 80 | 41.88 | 40 | 1.76 | 80 | 47.04 |
| 41 | 1.82 | 81 | 44.92 | 41 | 1.88 | 81 | 51.18 |
| 42 | 1.92 | 82 | 47.84 | 42 | 1.98 | 82 | 55.34 |
| 43 | 2.04 | 83 | 50.94 | 43 | 2.10 | 83 | 59.98 |
| 44 | 2.14 | 84 | 53.70 | 44 | 2.22 | 84 | 64.42 |
| 45 | 2.28 | 85 | 55.90 | 45 | 2.34 | 85 | 68.50 |
| 46 | 2.40 | 86 | 58.56 | 46 | 2.48 | 86 | 73.40 |
| 47 | 2.54 | 87 | 60.78 | 47 | 2.62 | 87 | 78.10 |
| 48 | 2.70 | 88 | 62.62 | 48 | 2.80 | 88 | 82.62 |
| 49 | 2.90 | 89 | 64.22 | 49 | 2.98 | 89 | 87.00 |
| 50 | 3.08 | 90+ | 65.14 | 50 | 3.18 | 90+ | 90.64 |
| 51 | 3.26 | | | 51 | 3.38 | | |
| 52 | 3.48 | | | 52 | 3.60 | | |
| 53 | 3.80 | | | 53 | 3.92 | | |
| 54 | 4.10 | | | 54 | 4.24 | | |
| 55 | 4.46 | | | 55 | 4.62 | | |
| 56 | 4.86 | | | 56 | 5.02 | | |
| 57 | 5.30 | | | 57 | 5.46 | | |
| 58 | 5.78 | | | 58 | 5.94 | | |
| 59 | 6.32 | | | 59 | 6.48 | | |

**Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.*
***Includes 100 percent home health care benefit.*

# 2005 Monthly Insurance Rates for Part-time Teachers

## Health

### Category I. 15-19 Hours

| COVERAGE LEVEL | EMPLOYEE | | | | | | EMPLOYER | |
|---|---|---|---|---|---|---|---|---|
| | Savings | Standard | Companion | CIGNA | MUSC Options | TRICARE Supplement | SHP/HMO | TRICARE |
| **Employee Only** | 120.08 | 204.26 | 212.38 | 208.60 | 209.82 | 0.00 | 110.80 | 63.50 |
| **Employee/Spouse** | 288.36 | 453.30 | 525.04 | 512.46 | 504.20 | 0.00 | 215.80 | 122.50 |
| **Employee/Child** | 176.58 | 298.76 | 382.66 | 372.66 | 346.64 | 0.00 | 156.30 | 122.50 |
| **Full Family** | 360.30 | 546.32 | 715.74 | 697.08 | 625.74 | 0.00 | 251.74 | 163.50 |

### Category II. 20-24 Hours

| COVERAGE LEVEL | EMPLOYEE | | | | | | EMPLOYER | |
|---|---|---|---|---|---|---|---|---|
| | Savings | Standard | Companion | CIGNA | MUSC Options | TRICARE Supplement | SHP/HMO | TRICARE |
| **Employee Only** | 82.40 | 166.58 | 174.70 | 170.92 | 172.14 | 0.00 | 148.46 | 63.50 |
| **Employee/Spouse** | 215.00 | 379.94 | 451.68 | 439.10 | 430.84 | 0.00 | 289.18 | 122.50 |
| **Employee/Child** | 123.44 | 245.62 | 329.52 | 319.52 | 293.50 | 0.00 | 209.44 | 122.50 |
| **Full Family** | 274.70 | 460.72 | 630.14 | 611.48 | 540.14 | 0.00 | 337.32 | 163.50 |

### Category III. 25-29 Hours

| COVERAGE LEVEL | EMPLOYEE | | | | | | EMPLOYER | |
|---|---|---|---|---|---|---|---|---|
| | Savings | Standard | Companion | CIGNA | MUSC Options | TRICARE Supplement | SHP/HMO | TRICARE |
| **Employee Only** | 46.96 | 131.14 | 139.26 | 135.48 | 136.70 | 0.00 | 183.92 | 63.50 |
| **Employee/Spouse** | 145.94 | 310.88 | 382.62 | 370.04 | 361.78 | 0.00 | 358.24 | 122.50 |
| **Employee/Child** | 73.42 | 195.60 | 279.50 | 269.50 | 243.48 | 0.00 | 259.46 | 122.50 |
| **Full Family** | 194.16 | 380.18 | 549.60 | 530.94 | 459.60 | 0.00 | 417.88 | 163.50 |

## Dental

| COVERAGE LEVEL | Category I. 15-19 Hours | | | Category II. 20-24 Hours | | | Category III. 25-29 Hours | | |
|---|---|---|---|---|---|---|---|---|---|
| | Employee | Employer | Dental Plus | Employee | Employer | Dental Plus | Employee | Employer | Dental Plus |
| **Employee Only** | 5.86 | 5.85 | 17.50 | 3.86 | 7.85 | 17.50 | 2.00 | 9.71 | 17.50 |
| **Employee/Spouse** | 13.50 | 5.85 | 33.14 | 11.50 | 7.85 | 33.14 | 9.64 | 9.71 | 33.14 |
| **Employee/Child** | 19.58 | 5.85 | 36.16 | 17.58 | 7.85 | 36.16 | 15.72 | 9.71 | 36.16 |
| **Full Family** | 27.20 | 5.85 | 51.80 | 25.20 | 7.85 | 51.80 | 23.34 | 9.71 | 51.80 |

# Glossary

## Actively at Work

Employees are considered actively at work on an employer's scheduled workday if they are performing in the usual manner all of the regular duties of their work on a full-time basis on that day, whether at their usual place of work or at another place if required to travel. Employees are also considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled workdays only if they were actively at work on the preceding scheduled workdays.

## Allowable Charge

The maximum amount a health plan (such as the State Health Plan, an HMO or Medicare) will pay for a covered service. Network providers and facilities are those that have agreed to accept the allowable charge for covered services under the plan.

## Annual Enrollment

A period **each** year during which eligible employees and retirees may change health plans only (SHP Savings to Standard, Standard to Savings, SHP to an HMO, HMO to SHP or HMO to another HMO). No other changes are allowed. Eligible subscribers may not change to or from the TRICARE Supplement plan or to or from the Medicare Supplemental Plan. See also *Open Enrollment*.

## Basic Salary

The actual amount an employee is paid by the employer per year, including merit and longevity increases. Basic salary does not include commissions, annuities, bonuses, overtime or incentive pay. For a teacher, basic salary does not include compensation for summer school.

## Child

See *Dependent Child.*

## COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985. This act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying event as defined in the act. See also *Qualifying Event*.

## Coinsurance

Coinsurance is the percentage of covered medical expenses a subscriber must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance because both the subscriber and the insurance plan share the cost of healthcare expenses.

## Coinsurance Maximum

The coinsurance maximum is the most money a subscriber would pay in eligible coinsurance each year before an insurance plan begins to pay 100 percent of the allowable charge for covered expenses. This does not apply to the Medicare Supplemental Plan.

## Coordination of Benefits

A system to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

## Copayment

A copayment is a fixed-dollar amount of covered medical expenses a subscriber must pay in addition to what is paid by an insurance plan for covered expenses. These amounts are called copayments because both the subscriber and the insurance plan share the cost of healthcare expenses.

## Copayment Maximum

The most money in eligible copayments a subscriber would pay each year before an insurance plan begins to pay the entire allowable charge for covered expenses.

## Covered Dental Expense

An expense that is provided for and deemed medically necessary by the plan up to the maximum amount listed in the *Schedule of Dental Procedures and Allowable Charges* (fee schedule) and that is not excluded by any term, condition, limitation or exclusion of the Plan.

## Covered Medical Expense

A medical expense that is provided for by an insurance plan. A covered expense is a charge that is not excluded by any term, condition, limitation or exclusion of the Plan.

## Covered Person

A person (employee, retiree, survivor, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan. See also *Enrollee* and *Subscriber*.

## Creditable Coverage

Prior coverage under a group health plan or insurance coverage or health benefits provided as described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage (a form from your previous insurance company listing your dates of coverage) may be used to reduce a pre-**existing condition limitation period, provided the prior coverage was continuous (any break in coverage did not exceed 62 days).**

## Deductible

The amount a subscriber must pay each year if an annual deductible, or each encounter if a per-occurrence deductible, toward covered expenses before the insurance plan begins paying benefits.

## Deferred Effective Date

A delayed effective date for insurance coverage, applicable to an employee who is absent from work due to injury or sickness on the date coverage would otherwise have become effective. The effective date is then deferred until the individual returns to work as an active, permanent, full-time employee for one full day.

## Dental Course of Treatment

All treatment performed in the mouth during one or more sessions as the result of the same diagnosis. Treatment includes examination, X-rays, prophylaxis and any complications arising from such treatment. Note: Some surgical procedures may be covered by a subscriber's health plan.

## Dental Deductible

The amount of covered dental expenses you must pay before the plan will pay Class II and Class III combined benefits.

## Dental Schedule of Procedures and Allowable Charges

The list of dental procedures covered by the State Dental Plan and the allowable charges for each procedure established by the Plan Administrator for the payment of covered dental services.

## Dentist

Dentist or physician licensed in the jurisdiction where services are performed and practicing within the scope of his license.

## Dependent Child

An unmarried child under 19 years of age (or under age 25 if a full-time student) and who is principally dependent (more than 50 percent) upon the subscriber for maintenance and support, provided the child is: (1) the natural or adopted child, stepchild, foster child (a child placed with the employee by an authorized placement agency and for whom the employee cares as he would his own child) or child for whom the subscriber has legal custody and who resides in the subscriber's home in a parent-child relationship; or (2) for whom the subscriber provides support and maintenance due to a court order. See also *"Full-time Student"* and *"Incapacitated Child."*

## Dependent Spouse

A lawful spouse of a subscriber, or former spouse required to be covered by a divorce

decree or court order, but not both your spouse and former spouse. If a spouse is also eligible for coverage or benefits as an employee of a participating employer, the spouse may not be covered as a dependent. However, a part-time teacher who is the spouse of a covered employee who is an employee of a participating employer may be covered as either an employee or as a dependent, but not as both.

## Employee

An employee is a person employed by the state, a school district or a participating local subdivision who must be working at least 30 hours* a week in a position classified by the employer as permanent and full-time, and who receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision. This includes clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipality councils who participate in the South Carolina Retirement Systems (SCRS) also are considered employees for insurance purposes. If you work for two covered employers (dual employment), please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and Vision Care Program benefits.

**Employers who participate in the Employee Insurance Program also have the option of reducing the threshold for insurance eligibility for permanent employees from 30 hours per week to at least 20 hours per week. This is at the option of the employer, and you should contact your benefits administrator for further information.*

## EIP

The Employee Insurance Program of the S.C. Budget and Control Board.

## Enrollee

A person (employee, retiree, survivor, COBRA participant or dependent) who has met the eligibility requirements and is enrolled in an insurance plan. See also *Covered Person* and *Subscriber*.

## Enrollment Date

(1) The hire date for an employee; (2) the effective date of coverage for an individual who enrolls under a special eligibility situation and for a late entrant; and (3) the retirement date for a retiree.

## Exclusion

A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

## Extended Care Benefits

Benefits that provide for medical care in a more cost-effective setting when hospitalization is not required or necessary. Extended care benefits include home healthcare, skilled nursing facility care, hospice care and alternative treatment plans.

## Funded Retiree

Funded retirees are those retirees who are eligible for the employer contribution to their retiree insurance premiums

## Full-time Student

An unmarried child who is 19 years of age but less than 25 years of age who is enrolled in and attending a high school, trade, vocational or technical school or college (not correspondence courses) on a full-time basis as defined by the institution.

## Health Maintenance Organization (HMO)

A managed care plan that has contractual arrangements with healthcare providers (doctors, hospitals, etc.) who together form a provider network. HMO subscribers are required to see only providers within this network. If a subscriber receives care outside of this network, the HMO will not pay benefits for these services unless the care was pre-authorized or

deemed an emergency. Subscribers choose a primary care physician (PCP) who coordinates all aspects of the subscriber's healthcare. To receive benefits, subscribers must receive a referral from their PCP before they can see a specialist.

## Home Healthcare

Part-time nursing care; health aide service; or physical, occupational or speech therapy provided by an approved home healthcare agency and given in the subscriber's home. These services do not include custodial care or care given by a person who ordinarily lives in the home or a member of the subscriber's family or the spouse's family.

## Hospital

A legally designated and operated institution caring for the sick, such as a general hospital; children's hospital; eye, ear, nose and throat hospital; maternity hospital or an ambulatory surgical center. "Hospital" also includes a legally constituted and operational psychiatric facility for the treatment of mental or nervous conditions or substance abuse. Hospitals must provide inpatient care given by, or supervised by, a staff of licensed physicians and must provide continuous 24-hour services by licensed registered nurses who are physically present and on duty. Nursing homes, rest homes, homes for the aged and convalescent homes are typically not considered hospitals under insurance plans, whether or not they are affiliated with a hospital.

## Incapacitated Child

An unmarried child who is incapable of self-sustaining employment because of mental illness or physical handicap and is principally dependent (more than 50 percent) on the subscriber for maintenance and support. Incapacitation must have begun before age 19 or while an eligible, covered, dependent, full-time student. If eligible but not previously covered, the child may not be added until the next open enrollment period (or within 31 days of a special eligibility situation), and coverage is subject to pre-existing condition limitations.

## Incurred Expense

An expense is considered incurred on the date services were rendered or supplies were received.

## Identification Number

For most plans, typically the covered person's Social Security number. Identification cards are issued by the insurance plan. Note for retirees: Under the State Health Plan Savings Plan, Standard Plan or Medicare Supplemental Plan, the retiree's Social Security number is used for all covered family members. Use the number listed on the Medicare card for Medicare claims and information. Note for survivors: For surviving spouses and surviving spouses with covered children, the surviving spouse's Social Security number is used for all covered family members. For surviving children only, the youngest child's Social Security number is used.

## Injury

An accidental bodily injury that requires treatment by a physician. Any loss that results from the injury must be independent of sickness or other causes.

## Late Entrant

A full-time employee or eligible retiree, and any eligible dependent of that employee or retiree, who is not enrolled within 31 days of that person's first date of eligibility and who subsequently enrolls during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

## Local Subdivision

Any participating employer covered by local jurisdiction rather than state. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed

legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. To be eligible to participate in the state insurance benefits program, a public employer in South Carolina must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

## Medi-Call

Medi-Call is the patient utilization review program for State Health Plan subscribers. Medi-Call ensures subscribers receive appropriate medical care in the most beneficial, cost-effective manner. Note: Retirees and dependents eligible for Medicare must call Medi-Call for home healthcare, hospice, durable medical equipment, Veterans Administration hospital services and when the number of hospital days allowed by Medicare is exceeded.

## Medically Necessary

Services or supplies ordered by a physician or behavioral healthcare provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the patient receives the service and in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

## Medicare Supplemental Plan

A health plan offered to retirees and their dependents who are eligible for Medicare. As a "supplemental" plan, it generally pays the deductibles and coinsurance for Medicare-approved services.

## Mental Health and Substance Abuse Provider

A physician, psychiatrist, health professional or institutional healthcare provider under agreement to participate in a behavioral health provider network administered by the APS Healthcare, Inc.

## Non-Funded Retirees

Non-funded retirees are those retirees who do not qualify for funded benefits and who must pay the full premium cost (includes retiree share plus employer contribution) for their insurance.

## Non-Preferred Brand Drugs

Medications that do not appear on the preferred drug list and that carry a higher copayment. All non-preferred drugs have an effective alternate option either as a generic or preferred brand drug.

## Notice of Election Form (NOE)

The Notice of Election (NOE) form is the application form used to enroll in benefits, add or delete dependents, or change coverage level, beneficiary, name or address.

## Open Enrollment

A period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan without regard to any special eligibility situations. Retirees may also change to and from the Medicare Supplemental Plan during an open enrollment period. Open enrollment is held in odd-numbered years during October. Enrollment changes become effective the following January 1.

## Out-of-Network Differential

If you choose to go to a healthcare provider that does not participate in a State Health Plan network, you will be responsible for a higher coinsurance percentage of your covered medical expenses and you may be balance-billed the difference between the allowed and actual charge. This out-of-network differential applies to all State Health Plan networks except the mental health and substance abuse and pharmacy networks, where no out-of-network benefits are provided.

## Out-of-Pocket Maximum

The maximum amount a covered person will be required to pay a year in deductibles, copayments and coinsurance. The amount is set by each insurance plan.

## Part-Time Teachers

Teachers, who are in a permanent position and work at least 15 hours but no more than 29 hours per week at a South Carolina public school, the South Carolina Department of Juvenile Justice or the South Carolina Department of Corrections are eligible for state health, dental, MoneyPlu$ and Vision Care Program benefits. They must also be in a contract position and receive an Education Improvement Act (EIA) salary supplement. Premiums are determined by the number of hours an eligible part-time teacher works per week.

## Participating Employer

A state agency, public school district, municipality or other group participating in the Plan.

## "Pay-the-Difference" Policy

If a generic drug is available and a subscriber chooses to purchase or his doctor prescribes the brand name medication instead, the benefit will be limited to the amount payable for the generic medication. The subscriber will be responsible for the difference in benefit between the brand-name drug and the generic drug, plus the generic copayment. The difference does not apply to annual copayment maximum.

## Per-Occurrence Deductible

The amount a covered person must pay each time he receives an emergency room, inpatient or outpatient hospital service before the health plan begins to pay benefits.

## Per-Visit Deductible

The amount a covered person must pay each time he receives services in a professional provider's office before the health plan begins to pay benefits.

## Physician

A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, psychiatrist or licensed counseling or clinical psychologist.

## Plan

The State Health Plan or the State Dental Plan.

## Plan Year

January 1 through December 31.

## Point of Service (POS)

A managed care plan that allows subscribers to choose to use providers or specialists within the plan's network as referred by their primary care physician, or subscribers can self-refer to a provider outside the network. Subscribers may use out-of-network services; however, benefits are paid at a reduced level.

## Pre-Existing Condition

Any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended by or received from a licensed healthcare provider or practitioner in the six months preceding the covered person's enrollment date. Benefits for a pre-existing condition are payable only for treatment provided at least 12 months (18 months for a late entrant) after enrollment. Pregnancy does not constitute a pre-existing condition. See also *Creditable Coverage.*

## Preferred Brand Drugs

Medications that have been determined safe, effective and available at a lower cost by Medco's Pharmacy and Therapeutics Committee. A list of preferred drugs is available at www.medco.com.

## Preferred Provider Organization

A PPO is a type of health or dental plan that is similar to a fee-for-service plan. A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's

allowable charges for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you.

## Premium

The amount a covered person pays in exchange for insurance coverage.

## Prescription Drugs

Any drugs or medicine required to bear the following wording, "Caution: Federal law prohibits dispensing without prescription." Insulin or drugs licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopoedia Publication, *Drug Information for Health Care Professionals*, are also considered prescription drugs. Drugs in FDA phase I, II or III testing are not covered.

## Primary Care Physician/Doctor

Usually the first contact for healthcare, this is often a family physician, internist, pediatrician, or in some cases, a gynecologist. A primary care physician monitors the patient's health and diagnoses and treats minor health problems and refers the patient to specialists if another level of care is necessary.

## Private Duty Nursing Services

Private services of a registered nurse or licensed practical nurse. Services must be certified in writing by a physician as medically necessary.

## Provider

Any person (i.e., doctor, nurse, dentist) or facility (i.e., hospital or clinic) that provides medical care.

## Qualifying Event

An event that allows insurance coverage or an extension of insurance coverage for an employee, spouse or dependent. Such events may be marriage, birth/adoption/placement, loss of group health plan coverage, divorce/legal separation, death of the covered employee, loss of dependent's eligibility for coverage.

## Self-Insured Plan

A self-insured insurance plan is one in which the employer or group of employers assumes direct financial responsibility for the costs of enrollees health claims. Employers sponsoring self-insured plans typically contract with an insurance carrier or third party administrator to provide administrative services for the self-insured plan.

## SHP

See *State Health Plan.*

## Sickness

A disease, disorder or condition that requires treatment by a physician.

## Significant Break in Coverage

A period of 63 or more consecutive days during which an individual does not have any creditable insurance coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. See also *Creditable Coverage.*

## Skilled Care

Services provided according to a physician's order, given by or under the direction of a qualified technical or professional healthcare provider. Healthcare providers include registered nurses, licensed practical nurses, physical therapists, speech pathologists and audiologists.

## Special Eligibility Situation

A qualifying event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include: marriage, birth, adoption or placement. Involuntary loss of other coverage applies only to those who lost coverage. Enrollment changes must be requested within 31 days of the qualifying event. Note: A salary increase does not constitute a special eligibility situation. See also *Qualifying Event*.

## Spouse

See *Dependent Spouse*.

## State Health Plan (SHP)

The term used generally to identify the Savings, Standard, and Medicare Supplemental plans.

## Subscriber

All active and retired employees, survivors and COBRA subscribers of state agencies, public school districts, participating counties and other eligible employers, and their dependents who are enrolled in a benefits plan. See also *Covered Person* and *Enrollee*.

## TERI

Teacher and Employee Retention Incentive program of the South Carolina Retirement Systems.

## Transfer/Transferring Employee

An active employee who changes employment from one state group employer to another with no more than a 15-calendar-day break in employment or in insurance coverage. An academic employee who completes a school term and moves to another academic setting at the beginning of the next school term is also considered a transferring employee. A transferring employee is not considered a new hire for insurance program purposes.

## You

Any person who is insured under the policy. You and/or your covered dependents.

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# Notes

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